

Rule and Policy Making for the Medicaid Program: A Challenge to Federalism

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I. INTRODUCTION

The Medicaid program provides health and long-term care insurance for some poor. Since its inception in 1965, the program has had a dramatic impact on improving access to health care services among the poor and thereby improving their health status.¹ Between 1965 and 1974, infant mortality rates in the United States declined 32 percent and death rates for young children from specific diseases, i.e., influenza and pneumonia, declined as much as 48 percent.² Immediate and substantial gains were also made regarding access to health care services. The proportion of poor failing to see a physician in a two-year period fell from 28 percent in the mid-1960s to 17 percent in 1973.³ Indeed, some evidence indicates that by the late 1970s, the poor saw physicians more often on average than the non-poor.⁴ In sum, the Medicaid program has been and continues to be a critical program for assuring health care for American society's most vulnerable members.

The Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS) administers the Medicaid program at the federal level. However, it is the states that have primary responsibility for the Medicaid program. There are many joint federal/state programs, but Medicaid is the largest and the most complicated. It comprises nearly 3 percent of the federal budget⁵ and is one of the largest components of state budgets. In fiscal year 1988, the federal government and states spent \$52.3 billion on the Medicaid program for 22.9 million people.⁶

Given the magnitude of the Medicaid program and the crucial nature of its mission, the relationship between HCFA and the states in the administration of

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1. See K. DAVIS & C. SCHOEN, *HEALTH AND THE WAR ON POVERTY: A TEN YEAR APPRAISAL* (1978); Davis, Gold & Makuc, *Access to Health Care for the Poor: Does the Gap Remain?*, 2 ANN. REV. PUBLIC HEALTH 159 (1981); Davis & Rowland, *Uninsured and Underserved: Inequities in Health Care in the United States*, 61 MILBANK MEM. FUND Q. 149 (1983); Blendon, *The Problems of Cost, Access, and Distribution of Medical Care*, 115 DAEDALUS 119 (1986).

2. K. DAVIS & C. SCHOEN, *supra* note 1, at 204.

3. *Id.* at 205.

4. L. ADAY, R. ANDERSON & G. FLEMING, *HEALTH IN THE U.S.: EQUITABLE FOR WHOM?* (1980).

5. EXECUTIVE OFF. OF THE PRESIDENT, OFF. OF MANAGEMENT AND BUDGET, *BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1990* (1989).

6. Off. of Nat'l Cost Estimates, *National Health Expenditures, 1988*, 11 HEALTH CARE FIN. REV. 22 (1988).

the Medicaid program is important and complex. This complexity has been exacerbated in recent years due to extensive fiscal pressures on the federal budget and the resulting efforts of the Executive Branch, as well as the states, to contain costs in the Medicaid program. The complexity has also been aggravated by a struggle over the fundamental mission of the Medicaid program between the administration of an ideologically conservative presidential administration and a more liberal Congress controlled by the opposition party.

This study examines the relationship between HCFA and the states in working out this struggle and specifically in implementing an enormous volume of federally generated changes in the Medicaid program since 1981. In a general sense, this article tells the story of a federal agency trying to craft rules and policies to implement mandated changes that are often opposed by the presidential administration in charge. It is also a story of the resulting confusion and sometimes chaos when the agency directs states to implement congressionally mandated changes within short time frames and without regard to conventional rule and policy making procedures which both federal and state agencies customarily follow. The story of the Medicaid program since 1981 is an interesting case study of the tensions created for a federal agency and the states when the executive and legislative branches of the federal government repeatedly fail to work out a political consensus about the mission of an important government program. This article concludes with recommendations for reforms in the rule and policy making process of the Medicaid program.

II. BACKGROUND ON THE MEDICAID PROGRAM

Congress established the Medicaid program in 1965 along with Medicare, a program to assist the elderly in meeting the high cost of health care.⁷ At the time, government health insurance was controversial, particularly within the medical profession and hospital community. Nevertheless, following the landslide victory of Democrat Lyndon Baines Johnson and an overwhelmingly Democratic Congress, passage of government health insurance for the elderly was inevitable.⁸

In the extraordinary compromise that gave birth to the Medicare and Medicaid programs, Congress borrowed from the two basic models in the Social Security Act. Congress adopted the welfare model for the Medicaid program's basic design.⁹ Like other welfare programs under the Social Security Act, Medicaid is jointly administered by the states and the federal government, financed by state and federal general revenues, and bases eligibility on a means test. Congress used the social insurance model for the Medicare program, which is characterized by federal administration, financed through a separate wage tax, and bases eligibility on beneficiary contributions during working years.

7. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1396-1396s (Medicaid) and 42 U.S.C. §§ 1395-1395ccc (Medicare) (1988)).

8. See generally R. STEVENS & R. STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 19-53 (1974).

9. *Id.* at 5-17.

Use of the welfare model for the Medicaid program has been problematic. When the Medicare and Medicaid programs proved to be far more expensive than anticipated,¹⁰ the Medicaid program was vulnerable politically because of its welfare character. For example, President Ronald Reagan, who came to office in 1981 with plans to curtail federal commitments to all entitlement programs, was able to achieve substantial cutbacks in the Medicaid program in part because of public and congressional perceptions that Medicaid was a welfare program.¹¹

The welfare model also permits great diversity among state programs. This diversity results in marked disparities in the treatment of similarly situated individuals across states in terms of who receives Medicaid benefits and how much of these benefits they receive.¹² Because states have great flexibility in structuring eligibility, benefits, coverage, and payment policies, the Medicaid program is really 50 very different programs serving different populations and providing different benefits. Evidence of the diversity among states is the disparity between Medicaid expenditures for states of similar size. For example, in 1985, New York with over 16 million people spent \$7.5 billion on its Medicaid program and Texas, with a population of comparable size, spent only \$1.4 billion.¹³ Similarly, despite having the same number of citizens in poverty, Wisconsin spent \$942 million in Medicaid expenditures while Oklahoma spent only \$460 million in 1985.¹⁴ These variations occur mainly because of the flexible eligibility rules which give states great latitude in setting income and resource standards for Medicaid eligibility for their residents.¹⁵ In sum, historically there has been no pretense of uniformity in the treatment of similarly situated individuals across states in terms of eligibility as well as the type and level of benefits received.¹⁶ This lack of uniformity may arguably be undesirable from an equity perspective but it follows inevitably from Congress' decision to adopt the welfare model under the Social Security Act, which gives states great authority to structure programs within federal constraints.

Because of its state/federal character, the Medicaid program raises the fundamental issues of federalism: Are all states committed and capable of executing the responsibility of financing health care for the poor even with substan-

10. See STAFF OF SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., *MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES* 41-44 (Comm. Print 1970).

11. See Omnibus Budget Reconciliation Act of 1981, §§ 2161-2184, Pub. L. No. 97-35 [hereinafter OBRA '81], 95 Stat. 357, 803-16 (codified at scattered sections of 42 U.S.C. §§ 1396-1396s (1988)). See *infra* note 143 and accompanying text.

12. See T. GRANNEMANN & M. PAULY, *CONTROLLING MEDICAID COSTS: FEDERALISM, COMPETITION, AND CHOICE* 21-29 (1983); Cromwell, Hurdle & Schurman, *Defederalizing Medicaid: Fair to the Poor, Fair to Taxpayers?*, 12 J. HEALTH POL., POL'Y & L. 1 (1987). See also McDevitt & Buczko, *Medicaid Program Characteristics and their Consequences for Program Spending*, 7 HEALTH CARE FIN. REV. 3 (1985).

13. Schneider, *Intergovernmental Influences on Medicaid Program Expenditures*, 148 PUB. ADMIN. REV. 756, 757 (1988). See generally Bachman, Altman & Beatrice, *What Influences a State's Approach to Medicaid Reform?*, 25 INQUIRY 243 (1988).

14. Schneider, *supra* note 13, at 757.

15. See *infra* notes 107-117 and accompanying text.

16. See K. ERDMAN & S. WOLFE, *POOR HEALTH CARE FOR POOR AMERICANS: A RANKING OF STATE MEDICAID PROGRAMS* (Pub. Citizens Health Res. Group, 1988).

tial federal assistance,¹⁷ and are resulting disparities in the treatment of protected groups by states tolerable? Students of federalism have often observed and documented that states tend to be more conservative politically and promote dominant economic interests to enhance the business opportunities in the state through low taxes and limited debt — policy goals which conflict with expanding state welfare programs.¹⁸ Nevertheless, promotion of increased responsibility of states over social programs was a major objective of the Executive Branch during the 1980s.¹⁹

The design of the Medicaid program has been the subject of debate since its inception. Proposals for national health insurance in the late 1960s and 1970s called for the elimination of state responsibility for health insurance for the poor except for long-term care.²⁰ In the 1980s, the debate continued in a different key. The Reagan administration proposed a "New Federalism" in which the federal government would assume complete responsibility for Medicaid and states would assume complete responsibility for Aid to Families with Dependent Children (AFDC).²¹ In the 1980s, both the American Medical Association and the American Hospital Association called for major reforms in the Medicaid program to expand health insurance coverage for the poor and uninsured.²² Also, private foundations and other prestigious coalitions of health sector interest groups engaged in similar analyses of the Medicaid program's design and offered proposals for reform.²³ Physician and hospital organizations concerned with child health have been particularly vocal advocates of Medicaid

17. See Thompson, *New Federalism and Health Care Policy: States and the Old Questions*, 11 J. HEALTH POL., POL'Y & L. 647, 648 (1986).

18. *Id.* at 648-49.

19. See Exec. Order No. 12,612, 52 Fed. Reg. 41,685 (1987). This Executive Order clearly states a policy preference for state responsibility for social problems and programs and requires that federal agencies review regulations and other agency actions to promote the following federalism principles:

(e) In most areas of governmental concern, the States uniquely possess the constitutional authority, the resources, and the competence to discern the sentiments of the people and to govern accordingly. . . .

(f) The nature of our constitutional system encourages a healthy diversity in the public policies adopted by the people of the several States according to their own conditions, needs, and desires. In the search for enlightened public policy, individual States and communities are free to experiment with a variety of approaches to public issues.

Id. at § 2, 52 Fed. Reg. 41,685.

20. See HOUSE SUBCOMM. ON HEALTH OF THE COMM. ON WAYS AND MEANS, 94TH CONG., 2D SESS., NATIONAL HEALTH INSURANCE RESOURCE BOOK (1976); DEP'T OF HEALTH AND HUMAN SERVICES, OFF. OF ASS'T SEC'Y FOR PLANNING AND EVALUATION, NATIONAL HEALTH INSURANCE WORKING PAPERS—DEP'T OF HEALTH AND HUMAN SERVICES (1980). See also K. DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS, AND CONSEQUENCES (1975); NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER (M. Pauly ed. 1980).

21. *President's Federalism Initiative: Hearings Before the Senate Comm. on Governmental Affairs*, 97th Cong., 2d Sess. (1982).

22. See, e.g., AM. MED. ASS'N AD HOC COMM. ON MEDICAID, INCLUDING THE POOR (1989); Tallon, *A Health Policy Agenda Proposal for Including the Poor*, 261 J. AM. MED. ASS'N 1044 (1989); Thorp, Siegel & Dailey, *Including the Poor: The Fiscal Impacts of Medicaid Expansion*, 261 J. AM. MED. ASS'N 1003 (1989); AM. HOSP. ASS'N, POLICY STRATEGY ON CARE FOR THE INDIGENT (1986); AM. HOSP. ASS'N, SPECIAL COMM. ON CARE FOR THE INDIGENT, COST AND COMPASSION: RECOMMENDATIONS FOR AVOIDING A CRISIS IN CARE FOR THE MEDICALLY INDIGENT (1986).

23. See, e.g., NAT'L HEALTH CARE CAMPAIGN, HEALTH CARE FOR ALL (1987); NAT'L STUDY GROUP ON STATE MEDICAID STRATEGIES, RESTRUCTURING MEDICAID: AN AGENDA FOR CHANGE (1983); MOLONEY, A COMMONWEALTH FUND PAPER: WHAT'S BEING DONE ABOUT MEDICAID? (1982); NEW APPROACHES TO THE MEDICAID CRISIS (R. Blendon & T. Moloney ed. 1982).

reform out of concern for the declining health and economic status of America's children in the 1980s.²⁴

In 1990, a coalition of children's advocacy groups, hospitals, health insurers and business groups in the "Children's Medicaid Coalition" successfully lobbied Congress to expand Medicaid benefits for poor children extensively in the Omnibus Budget Reconciliation Act of 1990.²⁵ Admitting that poor children are not their natural constituency, a Chamber of Commerce spokesperson stated that "Expansion of Medicaid to cover additional poor children will produce a better work force."²⁶

The design and future of the Medicaid program is also currently being debated in the context of proposals to provide government health insurance for the uninsured.²⁷ It is estimated that, in 1987, nearly 37 million Americans, about 15.5 percent of the population, had clearly inadequate or no health insurance.²⁸ The debate is also shaped by the current concern about how to finance long-term care for the elderly and disabled.²⁹ The Medicaid program is a major financier of long-term care services in the United States. In 1986, the Medicaid program paid 41 percent of expenditures for nursing home care.³⁰

Specifically, the United States Bipartisan Commission on Comprehensive Health Care, known as the "Pepper Commission," recently announced its proposal for universal health and long-term care insurance coverage for all Americans following a congressionally mandated study.³¹ The proposal calls for a

24. See, e.g., M. McMANUS & S. DAVIDSON, MEDICAID AND CHILDREN: A POLICY ANALYSIS (Am. Acad. of Pediatrics, 1982); AM. ACAD. OF PEDIATRICS, COMM. ON CHILD HEALTH FINANCING, *Medicaid Policy Statement*, 77 PEDIATRICS 762 (1986). See also S. LAUDICINA & D. LIPSON, MEDICAID AND POOR CHILDREN: STATE VARIATION IN ELIGIBILITY AND SERVICE COVERAGE (Nat'l Ass'n of Children's Hospitals and Related Institutions, 1988).

25. Omnibus Budget Reconciliation Act of 1990 §§ 4601-4607, Pub. L. No. 101-508 [hereinafter OBRA '90], 104 Stat. 1388 (codified at scattered sections of 42 U.S.C. § 1396a). See Pear, *Unlikely Allies Bring Expansion of Medicaid*, N.Y. Times, Nov. 4, 1990, at 1.

26. Pear, *supra* note 25, at 14.

27. See, e.g., INTERGOVERNMENTAL HEALTH POLICY PROJECT, MAJOR CHANGES IN STATE MEDICAID AND INDIGENT CARE PROGRAM, 1988 (1989); Cong. Res. Service, *Insuring the Uninsured: Options and Analysis* (Oct. 1988); Cong. Res. Service, *Health Insurance and the Uninsured: Background Data and Analysis* (May 1988); Wilensky, *Viable Strategies for Dealing with the Uninsured*, 6 HEALTH AFF. 33 (1987); Bovbjerg & Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857 (1986); Wilensky & Berk, *The Health Care of the Poor and the Role of Medicaid*, 1 HEALTH AFF. 50 (1982).

28. P. SHORT, A. MONHEIT & K. BEAUREGARD, UNINSURED AMERICANS: A 1987 PROFILE (Nat'l Cent. for Health Services Res. and Health Care Technology Assessment, 1988).

29. See, e.g., INTERGOVERNMENTAL HEALTH POLICY PROJECT, STATE CHANGES IN MEDICAID AND INDIGENT CARE PROGRAMS, 1988 1 (1989); COMM. ON NURSING HOME REG., INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986); *Long-Term Care in America: The People's Call for Federal Action: Hearings before the House Select Comm. on Aging*, 99th Cong., 1st Sess. (1985); *Budget Issues Related to Long-Term Health Care Coverage: Hearings Before the Task Force on Health of the House Comm. on the Budget*, 100th Cong., 1st Sess. (1987). See generally A. RIVLIN & J. WEINER, CARING FOR THE DISABLED ELDERLY: WHO WILL PAY? (1988).

30. HOUSE COMM. ON ENERGY AND COMMERCE, 100TH CONG., 2D SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 357 (Comm. Print 1988) [hereinafter MEDICAID SOURCE BOOK].

31. Medicare Catastrophic Coverage Act of 1988 § 401-08, Pub. L. No. 100-360, [hereinafter MCCA '88], 102 Stat. 683, 765-68.

sharply reduced role for the Medicaid program partly because of the known complexity for program beneficiaries.³²

There are some disturbing facts about the poor, their health care needs, and the Medicaid program that lie at the heart of this debate. These facts have inspired Congress to enact many of the benefit expansions in the Medicaid program, discussed below,³³ since 1981. While child poverty rose during the early 1980s, from 16 percent of all children in 1979 to 20 percent by 1983,³⁴ AFDC and Medicaid coverage of poor children declined.³⁵ Further, progress in reducing infant mortality rates was slowed with the rate for black infants being twice the rate for white infants.³⁶ Perhaps most disturbing is that the number of poor, with incomes below the federal poverty level, actually served by Medicaid sharply declined between the years 1979 and 1984. In 1979, Medicaid covered 84 percent of the poor, but by the mid-1980s, only 60 percent of the poor were covered.³⁷

III. PROGRAM DESIGN

The Medicaid program is a health insurance program jointly financed and administered by the federal government and the states. State participation in the program is optional.³⁸ The federal Medicaid statute, Title XIX of the Social Security Act,³⁹ sets forth: (1) mandatory features a state program must contain to qualify for federal financial support; (2) program options that states can elect to include; and (3) program areas for which states can get waivers of federal program requirements to adopt unique state approaches to providing and paying for health care services for Medicaid beneficiaries.

The federal government matches state dollars expended on the Medicaid program, but at different rates depending on the state's relative per capita income.⁴⁰ Match rates range from 78.42 percent for Mississippi to the minimum rate of 50 percent, which twelve states and the District of Columbia received in

32. U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE (THE "PEPPER COMM'N"), 101st Cong., 1st Sess., RECOMMENDATIONS TO CONGRESS: ACCESS TO HEALTH CARE AND LONG-TERM CARE FOR ALL AMERICANS (1990).

33. See *supra* notes 189-224 and accompanying text.

34. CHILDREN'S DEFENSE FUND, A VISION FOR AMERICA'S FUTURE, AN AGENDA FOR THE 1990s: A CHILDREN'S DEFENSE FUND BUDGET (1989).

35. Rowland, Lyons & Edwards, *Medicaid: Health Care for the Poor in the Reagan Era*, 9 ANN. REV. PUB. HEALTH 427, 431-34 (1988). See also S. Laudicina & D. Lipson, *supra* note 24.

36. *Infant Mortality Rates: Failure to Close the Black-White Gap: Hearings Before the Subcomm. on Oversight and Investigations and the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 98th Cong., 2d Sess. (1984). See also Regula, *National Policy and the Medically Uninsured*, 24 INQUIRY 48, 52 (1987).

37. *Id.*

38. Until recently, Arizona did not participate in the Medicaid program and has only participated with a unique demonstration program since the early 1980s. See Vogel, *AHCCS: A New Medicare-Medicaid Model in Arizona*, 309 NEW ENG. J. MED. 934 (1983); McCall, Henton, Crane, Haber, Freund & Wrightson, *Evaluation of the Arizona Health Care Cost-Containment System*, 7 HEALTH CARE FIN. REV. 77 (1985).

39. 42 U.S.C. §§ 1396-1396s (1988).

40. *Id.* at § 1396; 42 C.F.R. § 304.10 (1988). HCFA pays the federal match on a quarterly basis for the next quarter based on an estimate provided by the state. When HCFA and the state determine what the actual expenditures were for the quarter in question, HCFA reduces or increases the federal Medicaid payment for the next quarter accordingly. 42 U.S.C. § 1396b(d) (1988).

fiscal year 1986.⁴¹ The federal match comes from annual congressional appropriations, and the state contribution usually comes from state general revenues. In fiscal year 1987, the federal government paid about 54 percent of total Medicaid expenditures.⁴²

A. Program Administration

To participate in the Medicaid program, a state must submit a "state plan" to HCFA describing the nature and scope of its Medicaid program and giving assurances as to how it will meet federal requirements.⁴³ The state plan must assure that a single state agency administers the state's program.⁴⁴ Further, each state is required to have a Medical Care Advisory Committee to advise the state agency.⁴⁵ Federal law also requires that the state's program be in effect throughout the state⁴⁶ and that beneficiaries have the freedom to choose their providers.⁴⁷

1. Rule and Policy Making

The process for making rules and policies under the Medicaid program is complex in large part because of the shared federal and state responsibility for the program. To implement many program changes, HCFA often promulgates legislative rules pursuant to § 553 of the Administrative Procedure Act (APA).⁴⁸ The Social Security Act expressly accords the Secretary of HHS authority to promulgate rules and regulations "as may be necessary for the efficient administration of functions" under the Social Security Act.⁴⁹ Although rules pertaining to Medicaid benefits are exempt from § 553 rulemaking requirements under § 553(a)(2),⁵⁰ HHS announced in 1971 that it would generally observe § 553 in rulemaking for its programs.⁵¹

More often, HCFA issues interpretative or procedural rules and general statements of policy in its manuals that are directed at personnel in state Medicaid agencies and HCFA regional offices. Most of these instructions are com-

41. HEALTH CARE FINANCING ADMIN., PROGRAM STATISTICS: ANALYSIS OF MEDICAID PROGRAM CHARACTERISTICS, 1986 119 (Table 67) (1987).

42. *Id.*

43. 42 U.S.C. § 1396a(a) (1988); 42 C.F.R. § 430.10 (1988).

44. 42 U.S.C. § 1396a(a)(5) (1988).

45. *Id.*; 42 C.F.R. § 431.12 (1988). At least one court enjoined implementation of a state's plan to reduce coverage and reimbursement rates because the state's Medical Care Advisory Council was not consulted and the council did not include consumers or Medicaid recipients. *Jennings v. Alexander*, 518 F. Supp. 877 (M.D. Tenn. 1981), *aff'd in part and rev'd in part*, 715 F.2d 1036 (6th Cir.), *rev'd sub nom. Alexander v. Choate*, 469 U.S. 287 (1983). See also *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511 (5th Cir. 1983).

46. 42 U.S.C. § 1396a(a)(1) (1988).

47. *Id.* at § 1396a(a)(23).

48. 5 U.S.C. § 553 (1988). Section 553 of the APA requires that agencies provide notice and an opportunity for the public to participate in the rulemaking proceeding. For interpretative rules, general statements of policy, and rules of agency organization, procedure, or practice, compliance with § 553 notice-and-comment rulemaking procedures is not required. *Id.* at § 553(b)(3).

49. 42 U.S.C. § 1302 (1988).

50. 5 U.S.C. § 553(a)(2) (1988).

51. Dep't of Health, Educ. & Welfare, Notice, Public Participation in Rulemaking, 36 Fed. Reg. 2532 (1971).

piled in the *State Medicaid Manual*⁵² and other HCFA manuals and are updated periodically through "transmittals."⁵³ Others are issued as serially numbered program memoranda⁵⁴ or simply as letters from HCFA to states outlining various policy changes. In some cases, HCFA will prepare a "preprint" of a state plan amendment containing the policy change for states to incorporate into their state Medicaid plans.

States must then go through their own procedures for implementing the federal policy change and modify their own Medicaid program policies. To make major changes in their programs and also to respond to changes in federal law, rules, and policy, states must submit a "state plan amendment" to HCFA for approval.⁵⁵ Whenever a state plan or a state plan amendment is submitted to HCFA, HCFA must determine, within 90 days, whether it conforms to federal requirements.⁵⁶ HCFA may request additional information from the state and, once HCFA receives the information, HCFA has an additional 90 days on which to act on the state plan amendment.⁵⁷ If dissatisfied with HCFA's determination, a state may seek reconsideration from HHS within 60 days.⁵⁸ A state may then obtain judicial review of HHS' final decision not to approve a state plan or state plan amendment in the United States Court of Appeals for the circuit in which the state is located.⁵⁹

Some states have laws requiring that their legislatures enact laws to implement the new federal policy, a process that may cause considerable delay because of the sporadic schedules of many state legislatures. A state also has to promulgate its rules under its own administrative law requirements. Many states have rulemaking procedures that are comparable to notice-and-comment rulemaking under § 553 of the APA.⁶⁰ Indeed, most states require twenty or more days notice of the rulemaking proceeding as well as some opportunity for public participation, often through a mandated oral hearing.⁶¹ Moreover, many states require such procedures for all rules whether or not the agency intends them to be legislative or merely interpretative or procedural rules.⁶²

52. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL (1989).

53. Other manuals having program instructions related to the Medicaid program are: U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH CARE FIN. ADMIN., HCFA REGIONAL OFFICE MANUAL (1989); U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH CARE FIN. ADMIN., STATE OPERATIONS MANUAL (1989); U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH CARE FIN. ADMIN., THIRD PARTY LIABILITY IN THE MEDICAID PROGRAM: A GUIDE TO SUCCESSFUL STATE AGENCY PRACTICE (1989). See generally U.S. DEP'T OF HEALTH & HUMAN SERVICES, HEALTH CARE FIN. ADMIN., INFORMATION ON AVAILABILITY OF MEDICARE/MEDICAID MANUALS (1990).

54. HEALTH CARE FIN. ADMIN., MEDICAID PROGRAM MEMORANDA (1988).

55. 42 C.F.R. § 430.12(c) (1988). An approved plan amendment is usually effective from the first day of the quarter in which it was submitted. *Id.* at § 430.20. Also, as of 1981, if HCFA takes no action on the plan amendment, it is automatically approved after 90 days. *Id.* at § 430.16(a); OBRA '81, § 2177, 95 Stat. 357, 813 (current version at 42 U.S.C. § 1396n(f) (1988)).

56. 42 U.S.C. § 1316(a)(1) (1988).

57. 42 C.F.R. § 430.16(a) (1988).

58. *Id.* at § 1316(a)(2).

59. *Id.* at § 1316(a)(3). See *infra* note 67 and accompanying text.

60. See B. SCHWARTZ, ADMINISTRATIVE LAW § 4.13 (2d ed. 1983).

61. *Id.*

62. *Id.*

2. Enforcement of Federal Requirements

a. Compliance Actions

HCFA has several methods to ensure state compliance with federal requirements. One is a compliance action through which HCFA makes a determination that the state plan or the state's implementation of the plan is out of compliance with federal Medicaid requirements in some respect.⁶³ In this action, HCFA may withhold payment of all or part of federal matching funds prospectively only until the state remedies the noncompliance issue.⁶⁴ As a practical matter, HCFA endeavors to negotiate most noncompliance issues with the state. If negotiations break down, a state may obtain reconsideration of HCFA's decision within 60 days⁶⁵ and a formal administrative hearing before a HCFA official.⁶⁶ Judicial review of HHS' final decision is available in the United States Court of Appeals for the circuit in which the state is located.⁶⁷

b. Disallowance Actions

Another administrative process addressing noncompliance with federal requirements is the disallowance action in which HCFA retrospectively disallows the federal match for state Medicaid expenditures on grounds that the expenditure did not meet federal requirements. The statute does not directly authorize a disallowance action except with respect to the state's right to reconsideration in Social Security Act § 1116(d).⁶⁸ The disallowance action is predicated on the statutory provisions pertaining to federal payment of states,⁶⁹ and federal Medicaid regulations do outline a "disallowance" action.⁷⁰ Most issues over compliance with federal program requirements are raised in the context of a disallowance action⁷¹ rather than a noncompliance action.⁷²

If a disallowance issue is not resolved, the state can appeal HCFA's decision to the Departmental Appeals Board (DAB) in HHS.⁷³ A dissatisfied party

63. 42 U.S.C. § 1396c (1988); 42 C.F.R. § 430.10-20 (1988).

64. 42 U.S.C. § 1316c (1988); 42 C.F.R. § 430.35 (1988).

65. 42 U.S.C. § 1316(a)(2) (1988); 42 C.F.R. § 430.18(a) (1988).

66. 42 C.F.R. §§ 430.18 & 430.60-104.

67. 42 U.S.C. § 1316(a)(3) (1988); 42 C.F.R. § 430.38 (1988).

68. 42 U.S.C. § 1316(d) (1988).

69. *Id.*

70. 42 C.F.R. §§ 430.42-430.48 (1988).

71. *See, e.g.,* *Bowen v. Massachusetts*, 487 U.S. 879, 882 n.1 (1988), *aff'g in part, rev'g in part*, 816 F.2d 796 (1st Cir. 1987); *Massachusetts v. United States*, 815 F.2d 778 (1st Cir. 1988); *Connecticut Dep't of Income Maintenance v. Heckler*, 471 U.S. 524 (1985); *Maryland Dep't of Human Resources v. DHHS*, 763 F.2d 1441 (D.C. Cir. 1985); *Minnesota ex rel. Noot v. Heckler*, 718 F.2d 852 (8th Cir. 1983); *Massachusetts v. Secretary*, 749 F.2d 89 (1st Cir. 1984), *cert. denied*, 472 U.S. 1017 (1984); *Illinois Dep't of Pub. Aid v. Schweiker*, 707 F.2d 273 (7th Cir. 1983); *Massachusetts v. Departmental Grant Appeals Bd.*, 698 F.2d 22 (1st Cir. 1983); *Medical Services Admin. v. United States*, 590 F.2d 135 (5th Cir. 1979); *County of Alameda v. Weinberger*, 520 F.2d 344 (9th Cir. 1975); *Virginia v. Bowen*, 683 F. Supp. 148 (W.D. Va. 1988); *Delaware Div. of Health & Social Services v. DHHS*, 665 F. Supp. 1104 (D.Del. 1987); *Indiana Dep't of Pub. Welfare v. Bowen*, 686 F. Supp. 692 (S.D. Ind. 1987); *Georgia v. Califano*, 446 F. Supp. 404 (N.D. Ga. 1977).

72. *See, e.g.,* *Connecticut Dep't of Pub. Welfare v. DHEW*, 448 F.2d 209 (2d Cir. 1971); *Cubanski v. Heckler*, 781 F.2d 1421 (9th Cir. 1986).

73. 42 C.F.R. pt. 430 (1988); 45 C.F.R. pt. 16 (1988). *See generally* Cappalli, *Model for Case Management: The Grant Appeals Board*, 1986 ACUS 663; Admin. Conf. of United States, Recommendation 86-7: Case

can obtain reconsideration by the board on grounds of a clear error of fact or law.⁷⁴ Unlike compliance actions, there is no express statutory authority for judicial review of disallowance actions. Section 1116 of the Social Security Act permits a state to obtain the Secretary's reconsideration of a disallowance.⁷⁵ Although there has been confusion about the availability of judicial review in disallowance decisions in the past, at least five circuit courts and the Supreme Court, in *Bowen v. Massachusetts*,⁷⁶ have agreed that states may seek judicial review of the Secretary's final decision in federal district court.⁷⁷

c. *Quality Control System*

Another important program for enforcing federal requirements is the "quality control" system established in the late 1970s to monitor state decision-making on eligibility and claims and thereby contain costs in the Medicaid program.⁷⁸ The chief purpose of this quality control program is to identify errors in eligibility determinations, coverage of services or payment of providers through the review of a sample of Medicaid claims.⁷⁹ The error rate in the sample, based on those claims improperly paid, is assumed to be the error rate for all of the state's Medicaid claims. If this error rate is greater than three percent, federal payment for all Medicaid claims is reduced by a percentage equal to the excess error rate. This penalty is imposed in lieu of a disallowance for a specific error.⁸⁰

B. *Eligibility, Benefits and Coverage Requirements*

1. *Eligibility*

The eligibility requirements for the Medicaid program are complex and, frankly, byzantine. Congress initially predicated Medicaid eligibility on eligibility for the Aid to Families with Dependent Children (AFDC)⁸¹ and the Supplemental Security Income (SSI) programs.⁸² Since Medicaid's inception, Con-

Management as a Tool for Improving Agency Adjudication, 1 C.F.R. § 305.86-7 (1988). This recommendation proposed several measures to facilitate adjudication before the board including step-by-step time goals, expedited options (particularly for small cases), adoption of questioning techniques by the hearing officer to develop the record on key points, joint consideration of cases with common issues, use of mediation, etc. *Id.* Recently, DAB has taken a more active role in promoting mediation to resolve disputes. See DEP'T OF HEALTH & HUMAN SERVICES, DEP'T APPEALS BD., *MEDIATION: THE FAST, LOW COST ALTERNATIVE* (1989).

74. 45 C.F.R. § 16.13 (1988).

75. 42 U.S.C. § 1316(d) (1988).

76. 487 U.S. 879 (1988).

77. *Bowen v. Massachusetts*, 816 F.2d 796 (1st Cir. 1987), *aff'd in part, rev'd in part*, 487 U.S. 879 (1988); *Maryland Dep't of Human Resources v. DHHS*, 763 F.2d 1441 (D.C. Cir. 1985); *Minnesota ex rel. Noot v. Heckler*, 718 F.2d 852 (8th Cir. 1983); *Department of Pub. Aid v. Schweiker*, 707 F.2d 273 (7th Cir. 1983); *County of Alameda v. Weinberger*, 520 F.2d 344 (9th Cir. 1975).

78. 42 U.S.C. § 1396u(3) (1988); Final Rule, Medicaid Quality Control (MQC) System, 43 Fed. Reg. 45,188 (Sept. 29, 1978) (codified as amended at 42 C.F.R. §§ 431.800-431.804 (1988)); HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL, Part 7 (1988).

79. MEDICAID SOURCE BOOK, *supra* note 30, at 181-83.

80. See *supra* notes 68-72 and accompanying text.

81. 42 U.S.C. §§ 601-616(f) (1988).

82. *Id.* at §§ 1381-1383c. Initially, Congress based eligibility on the predecessor programs of SSI, i.e., Old Age Assistance, Aid to the Blind and Aid to the Disabled. Social Security Amendments of 1965, §§ 1901-1905,

gress has repeatedly changed eligibility requirements to address specific needs.⁸³ The result of such eligibility expansions is a highly technical, virtually incomprehensible body of Medicaid eligibility law.

As a political compromise to states concerned about an expensive increase in the number of Medicaid beneficiaries with the creation of the SSI program in 1972,⁸⁴ § 209(b) of the Social Security Amendments of 1972 gave states the option of covering only those aged, blind, and disabled that meet the more restrictive requirements of state cash assistance programs for these groups in place in 1972 rather than the more generous SSI eligibility requirements.⁸⁵ About one quarter of the states have adopted this option and are called "209(b) states."⁸⁶

One consequence of predicated Medicaid eligibility on meeting characteristics of two categorical assistance programs is to create two distinct and very different groups of Medicaid beneficiaries. One group, AFDC recipients, are young women and children, predominantly minorities.⁸⁷ The other group, SSI recipients, are generally old, severely disabled and, more often, white.⁸⁸ These two groups have very different public reputations, constituencies, and political clout. While constituting the smaller percentage of Medicaid eligibles (27.8 percent in 1988), those receiving Medicaid on the basis of SSI eligibility receive the great majority of expenditures (73.2 percent in 1988).⁸⁹

a. Eligibility Groups

A state program *must* include the so-called "mandatory categorically needy." These are recipients of the AFDC program and, in non-209(b) states, the SSI program.⁹⁰ Mandatory categorically needy also includes groups of individuals who, for fairly technical reasons, are not eligible for AFDC or SSI but

Pub. L. No. 89-97, 79 Stat. 288, 344-51 (1965). In 1972, Congress consolidated these three programs into the federally financed SSI program. Social Security Amendments of 1972, § 301, Pub. L. No. 92-603, 86 Stat. 1332, 1465 (1972) (codified as amended at 42 U.S.C. § 1381 (1988)).

83. These eligibility expansions are numerous and have highly technical qualification requirements. The best description of these eligibility expansions and the statutory and regulatory authority on which they are based is contained in 3 MEDICARE & MEDICAID GUIDE (CCH) ¶¶ 14,211-14,381 (1990). See also MEDICAID SOURCE BOOK, *supra* note 30, at 54-78.

84. S. Rep. No. 93-553, 56 (1972).

85. Social Security Amendments of 1972, § 209(b), 86 Stat. 1381-82 (current version at 42 U.S.C. § 1396a(f) (1988)).

86. The following states are "209(b) states": Connecticut, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, Utah and Virginia. See 3 MEDICARE AND MEDICAID GUIDE (CCH) ¶¶ 15,550-15,660 (1990).

87. For Fiscal Year 1987, 36.6 percent of AFDC recipients were white, 1.3 percent native American, 16.2 percent Hispanic, 40.4 percent Black, 3.0 percent Asian, and 2.5 percent unknown. DEP'T OF HEALTH & HUMAN SERVICES, FAMILY SUPPORT ADMIN., OFF. OF FAMILY ASSISTANCE, *Characteristics and Financial Circumstances of AFDC Recipients, 1987* (1987).

88. Of the 82.1 percent of SSI recipients for whom data were reported, 52.2 percent were white, 24.9 percent were Black, and 5 percent were reported as "other." The categorical breakdown according to eligibility for 100 percent of SSI recipients was 32.5 percent aged, 1.9 percent blind, and 65.6 percent disabled. A person who begins to receive SSI as a blind or disabled person continues to be categorized as such after turning 65. 1988 Soc. Sec. BULL. 74, 75 (Tables Q-17, Q-20).

89. MEDICAID SOURCE BOOK, *supra* note 30, at 4-5.

90. See *supra* note 80 and accompanying text.

still have incomes at or near the applicable AFDC or SSI levels.⁹¹ States basically set the need standard and payment levels for their AFDC populations and consequently eligibility for AFDC varies widely from state to state.⁹²

Since the mid-1980s, Congress has actively sought to equalize Medicaid eligibility for poor infants, children and mothers and move away from simply basing the eligibility of these groups on AFDC eligibility, which varies widely from state to state.⁹³ In the Omnibus Budget Reconciliation Act of 1989, Congress continued a five-year effort to expand mandatory coverage for infants, children and mothers⁹⁴ by requiring that by 1990, states must cover pregnant women and children under age six born after 1983 whose incomes are at or below 133 percent of the federal poverty level.⁹⁵ In the Omnibus Budget Reconciliation Act of 1990, Congress, in an extraordinary step given the desperate search for budget cutting opportunities associated with the passage of that legislation,⁹⁶ expanded mandatory coverage further for all children under age 19 and pregnant women to be phased in over several years.⁹⁷ This eligibility expansion is a major effort to simplify the program and to treat similarly situated poor in different states in a uniform manner.

States also have the option of covering other groups of individuals, called the "optional categorically needy," who also do not qualify for AFDC or SSI for fairly technical reasons.⁹⁸ In general, these groups have slightly higher incomes than applicable SSI or AFDC levels. One example of the optional categorically needy are children under age seven born after 1983 and pregnant women whose incomes are under 185 percent of the federal poverty level.⁹⁹ Another key group is institutionalized blind, disabled, or elderly individuals with incomes up to 300 percent of the SSI income eligibility level.¹⁰⁰ In 1986, Congress also gave states the option of covering all elderly and disabled whose incomes were under 100 percent of the federal poverty level.¹⁰¹

States are also given the option of covering the "medically needy." These are individuals who, except for their income or resources, meet the other eligi-

91. 42 U.S.C. §§ 1396a(a)(10), & 1396b(a) (1988); 42 C.F.R. §§ 435.100-435.136, 436.100-436.124 (1988). See MEDICAID SOURCE BOOK, *supra* note 30, at 58-59, 64-66.

92. MEDICAID SOURCE BOOK, *supra* note 28, at 55-57 & Table II-2.

93. See *supra* note 92 and accompanying text.

94. See *infra* notes 189, 193, 205-06, 213 and 229 and accompanying text.

95. Omnibus Budget Reconciliation Act of 1989 § 6401, Pub. L. No. 101-239 [hereinafter OBRA '89], 103 Stat. 2258-59 (codified at 42 U.S.C. § 1396a(a)(10)).

96. Hager, *Deficit Deal Ever So Fragile as Hours Dwindle Away*, CONG. Q., Oct. 27, 1990, at 3574.

97. OBRA '90, §§ 4601 & 4603, 104 Stat. 1388 (to be codified at 42 U.S.C. § 1396a(a)(10)(A) & 1396a(e)). See *infra* note 239 and accompanying text.

98. 42 U.S.C. §§ 1396a(a)(10), 1396b(a) (1988); 42 C.F.R. §§ 435.200-435.231 & 435.200-435.230 (1988). See MEDICAID SOURCE BOOK, *supra* note 30, at 59-61, 66-69.

99. 42 U.S.C. § 1396a(a)(10)(A)(ii) (1988). States have generally taken advantage of this optional eligibility expansion for children and pregnant women. By Spring 1988, 33 states had accordingly adopted expanded eligibility criteria for these groups. See I. HILL, BROADENING MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN: STATE POLICY RESPONSES (1987); I. HILL, REACHING WOMEN WHO NEED PRENATAL CARE: STRATEGIES FOR IMPROVING STATE PERINATAL PROGRAMS (1988).

100. 42 C.F.R. §§ 435.721-435.722, 435.1005 (1988).

101. See *infra* note 207.

bility requirements for SSI or AFDC.¹⁰² To be eligible for federal matching funds, the income of the medically needy person after deduction of medical expenses cannot exceed 133 percent of the state's AFDC standard,¹⁰³ except that the gross income of institutionalized medically needy can reach 300 percent of the SSI income level.¹⁰⁴ The medically needy program basically offers catastrophic health and long-term care insurance for lower income people who must "spend down" their income and resources to obtain Medicaid eligibility. Seventy percent of states have this type of program.¹⁰⁵ Most of the states without such programs are in the South and Southwest.¹⁰⁶

b. *Income and Resource Determinations*

Determining Medicaid eligibility is complex. The chief reason is the detailed and technical income and resource requirements imposed by federal and state law that beneficiaries must meet to become eligible for Medicaid.¹⁰⁷ Income and resource determinations are particularly complicated in 209(b) states which may use eligibility rules of the 1972 categorical assistance programs for the aged, blind, and disabled rather than the simpler eligibility rules for the SSI program.¹⁰⁸ Of all issues affecting beneficiaries, no other has generated the amount of litigation that various income and resource requirements have,¹⁰⁹ including several cases before the Supreme Court.¹¹⁰

One of the most complex and controversial aspects of this determination, particularly in 209(b) states, is whether and the extent to which income of one's spouse or the parents of children under 21, blind, or disabled, is "deemed" available to the applicant for purposes of determining Medicaid eligibility.¹¹¹ The Medicaid "deeming" rules have been particularly controversial in the case of spouses where one is institutionalized,¹¹² although Congress liberalized these

102. 42 U.S.C. § 1396a(10)(C) (1988). See generally NAT'L HEALTH LAW PROG., AN ADVOCATE'S GUIDE TO THE MEDICALLY NEEDED PROGRAM (1985).

103. 42 U.S.C. § 1396a(10)(A), 42 C.F.R. § 435.811 (1988).

104. *Id.* at §§ 435.721, 435.722, 435.1005.

105. 3 MEDICARE & MEDICAID GUIDE (CCH) ¶¶ 15,550-15,660 (1989).

106. See *id.*

107. 42 U.S.C. § 1396a(a)(17) (1988).

108. See *supra* note 85 and accompanying text.

109. See, e.g., *Mallow v. Eichler*, 860 F.2d 1179 (3d Cir. 1988); *Childress v. Bowen*, 833 F.2d 231 (10th Cir. 1987); *Mitchell v. Lipscomb*, 851 F.2d 734 (4th Cir. 1988); *Olson v. Norman*, 830 F.2d 811 (8th Cir. 1987); *Vance v. Hegstrom*, 793 F.2d 1018 (9th Cir. 1986); *Hogan v. Heckler*, 769 F.2d 886 (1st Cir. 1985), *cert. denied*, 478 U.S. 1007 (1986); *Winter v. Miller*, 676 F.2d 276 (7th Cir. 1982); *Brown v. Smith*, 662 F.2d 464 (7th Cir. 1981); *Norman v. St. Clair*, 610 F.2d 1228 (5th Cir. 1980), *cert. denied*, 453 U.S. 922 (1984); *Mowbray v. Kozlowski*, 724 F. Supp. 404 (W.D. Va. 1989).

110. See, e.g., *Atkins v. Rivera*, 477 U.S. 154 (1986); *Herweg v. Ray*, 455 U.S. 265 (1982); *Schweiker v. Hogan*, 457 U.S. 569 (1982); *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981).

111. 42 U.S.C. § 1396a(a)(17) (1988). In *Gray Panthers*, 453 U.S. at 34, the Supreme Court upheld federal regulations pertaining to deeming of income in 209(b) states. The Court stated that, because of the intricacies of the Medicaid statute, Congress intended that the Secretary have broad authority to promulgate implementing regulations. See *Herweg*, 455 U.S. at 265 (upholding regulation regarding deeming of income in states using SSI standards). See *infra* notes 272-79 and accompanying text.

112. See MEDICAID SOURCE BOOK, *supra* note 30, at 79-84. See also *Mitchell, Spousal Impoverishment: Medicaid Burdens on the At-Home Spouse of a Nursing Home Resident*, 20 CLEARINGHOUSE REV. 358 (1986); *Drizner, Medicaid's Unhealthy Side Effect: The Financial Burdens on At-Home Spouses of Institutionalized Recipients*, 18 LOY. U. CHI. L.J. 1031 (1987).

rules considerably in 1988 even for 209(b) states.¹¹³ There are also strict rules governing the degree to which people can transfer assets to relatives in order to meet Medicaid eligibility requirements.¹¹⁴

The Medicaid eligibility determination process is so complex, particularly with respect to documenting income and resources and determining whether applicants have "spent down" their income and resources to qualify for Medicaid, that many beneficiaries do not complete the process of applying for Medicaid benefits. One study of seventeen Southern states found that, in fiscal year 1985-1986, 63 percent of all applications by mothers with children were denied due to the applicant's "failure to comply with procedural requirements."¹¹⁵ This study also found that the number of applications denied on this ground increased 75.2 percent between 1980 and 1986.¹¹⁶ This is an extremely disturbing finding, for it suggests that complex application procedures discourage potentially eligible applicants from even completing the application process. Elderly and disabled beneficiaries have comparable problems, as evidenced by startling testimony in a recent congressional hearing recounting the experiences of elderly Medicaid applicants in one 209(b) state¹¹⁷ who ultimately did not qualify for Medicaid because of extensive reporting and verification requirements regarding income and resources.

It would be appropriate for Congress, HCFA, and the states to devise ways to simplify the eligibility determination process. It does appear that the complexity of Medicaid eligibility law, rules, and policy at the federal and state level is having a serious impact on the administration of eligibility determinations to the detriment of the most destitute and unsophisticated persons in our society.

113. MCCA '88 § 303(a)(1) (codified at 42 U.S.C. § 13961-5 (1988)). See MEDICAID SOURCE BOOK, *supra* note 30, at 84-86.

114. 42 U.S.C. §§ 1396a(a)(18), 1396p (1988). See Herron, *Medicaid Eligibility and Transfer of Assets: Randall v. Lukhard*, 4 DET. C.L. REV. 997 (1984); Deford, *Medicaid Liens, Recoveries, and Transfer of Assets After TEFRA*, 18 CLEARINGHOUSE REV. 134 (1984).

Since 1983, HCFA permits states to make adult family members financially responsible for family members on Medicaid if the state has a family responsibility statute of general applicability. HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL § 3812 (1982). The Medicaid statute prohibits states from taking into account the financial responsibility of anyone but spouses or parents. 42 U.S.C. § 1396a(a)(17)(D) (1988). Nevertheless, HCFA takes the view that, if states have a statute requiring such financial support for all welfare programs, states can apply that statute to their Medicaid programs. See Whitman & Whitney, *Are Children Legally Responsible for the Support of their Parents? The 1983 Medical Eligibility Transmittal Harms the People Involved and Should be Withdrawn*, 123 TR. & EST. 43 (1984); Patrick, *Honor Thy Father and Mother: Paying the Medical Bills of Elderly Parents*, 19 U. RICH. L. REV. 69 (1984).

115. S. SHUPTRINE & V. GRANT, STUDY OF THE AFDC/MEDICAID ELIGIBILITY PROCESS IN THE SOUTHERN STATES FOR THE SOUTHERN REGIONAL PROJECT ON INFANT MORTALITY 1 (So. Governor's Ass'n & So. Legislative Conf., 1988). See Colburn, *Bureaucratic Barriers to Medicaid Benefits*, Wash. Post Health, June 21, 1988, at Z7.

116. S. SHUPTRINE & V. GRANT, *supra* note 115, at 9.

117. *Public/Private Partnerships: Innovative Approaches to Long-Term Care: Hearing Before the Subcomm. on Aging of the Senate Comm. on Labor and Human Resources*, 100th Cong., 1st Sess. 88-109 (1990) (Testimony of Scott R. Severns, Esq.).

2. Benefits and Coverage

a. Benefits

The federal Medicaid statute specifies the benefits that state programs must cover to qualify for federal matching funds and identifies specific additional benefits that states have the option of covering.¹¹⁸ States *must* cover the following benefits to the mandatory categorically needy and, if the state program includes them, the optional categorically needy: inpatient hospital services, laboratory, x-ray and physician services, early and periodic screening diagnosis and treatment (EPSDT) services for children, family planning services and supplies, nurse midwife services, and nursing facility and home health services for individuals 21 and older.¹¹⁹ States *may* cover dental services, physical therapy and related services, home health and preventive services, drugs, eye glasses, and nursing home services.

The mandatory benefit of nursing home care and intermediate care is a crucial and widely used Medicaid benefit for the elderly and disabled as well as the mentally retarded. In 1986, as noted above, Medicaid paid 41 percent of all nursing home expenditures.¹²⁰ In addition, 30 percent of all Medicaid disbursements were for nursing home care in 1986.¹²¹

States have greater flexibility in structuring the benefit package for their medically needy programs. However, any medically needy program must include prenatal and delivery care for pregnant women, ambulatory health care services and home health care for individuals entitled to skilled nursing home services.¹²²

b. Coverage Policy

Coverage of services must be "sufficient in amount, duration and scope to reasonably achieve their purpose[s]."¹²³ States may limit coverage to medically necessary services¹²⁴ and may even impose fixed limits on the amount of a particular type of covered service, such as hospital days or physician visits.¹²⁵ To assure that states do not unduly favor one group of Medicaid eligibles over another, there are limits on the degree to which states can provide coverage of benefits for some groups of Medicaid eligibles and not for others.¹²⁶ In addition,

118. 42 U.S.C. § 1396d(a)(1)-(17) (1988).

119. 42 C.F.R. § 440.210 (1988). See MEDICAID SOURCE BOOK, *supra* note 30, at 93-96.

120. See *supra* note 30 and accompanying text.

121. MEDICAID SOURCE BOOK, *supra* note 30, at 33.

122. 42 C.F.R. § 440.220 (1989).

123. *Id.* at § 440.170 (1988).

124. 42 U.S.C. § 1396a(a)(10) (1988); 42 C.F.R. pt. 410 (1988).

125. See *Curtis v. Taylor*, 625 F.2d 645 (5th Cir. 1980) (upholding Florida's limit on number of physician visits). See cases cited *infra* in note 144 (cases brought by hospitals and nursing homes to challenge limits on inpatient days). Also, in *Alexander v. Choates*, 469 U.S. 287 (1985), the Supreme Court ruled that a state's limitation on coverage of inpatient hospital days did not violate § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1988).

126. Specifically, coverage for all groups of categorically needy must be equal in amount, duration, and scope and at least equivalent to coverage for the medically needy. 42 U.S.C. § 1396a(a)(10)(B) (1988); 42 C.F.R. § 440.240 (1988). Similarly, coverage of services within each group of medically needy must also be equal in

states cannot arbitrarily discriminate in benefit coverage for mandatory services on the basis of diagnosis, type of illness or condition.¹²⁷ States do not have to cover organ transplants, but they must submit a state plan amendment outlining the criteria for coverage to HCFA if they do.¹²⁸ As a result of these flexible rules, there is considerable variation among states as to coverage of both mandated and optional Medicaid benefits.¹²⁹

C. *Payment of Providers*

States also have considerable flexibility in setting the level and method for paying providers of services. In 1987, 42 states had prospective payment systems for inpatient hospital care and all but four states used such systems for nursing home care.¹³⁰ Three states, California, Illinois and Vermont, have a waiver of Medicaid program requirements to negotiate rates directly with particular hospitals through selective contracting systems.¹³¹ The majority of states use fee schedules to base physician payment.¹³² For hospital outpatient departments, most states use either fee schedules or some type of cost reimbursement scheme.¹³³

There are federal requirements for state payment methodologies, many of which have proven controversial in their implementation.¹³⁴ First, only providers who accept Medicaid reimbursement as payment in full can participate in the Medicaid Program.¹³⁵ However, states may also impose nominal co-payments on beneficiaries for some services.¹³⁶ State payment rates must be consistent with efficiency, economy and quality of care.¹³⁷ At least annually, states must make findings that their payment rates for hospitals and nursing homes meet federal requirements and also do not exceed Medicare payment rates.¹³⁸

amount, duration, and scope except where otherwise authorized by regulation. 42 U.S.C. § 1396a(a)(10)(B) (1988); 42 C.F.R. § 440.240 (1988). Coverage of services provided by health maintenance organizations (HMOs) must be of comparable amount, duration, and scope as non-HMO services. 42 U.S.C. § 1396b(m)(1)(A)(i) (1988).

127. *Id.* at § 1396a(a)(1)-(5); 42 C.F.R. pt. 411 (1988). *See, e.g.,* Pinneke v. Presser, 623 F.2d 546 (8th Cir. 1980); Allen v. Mansour, 681 F. Supp. 1232 (E.D. Mich. 1986); Weaver v. Reagan, 701 F. Supp. 717 (W.D. Mo. 1988). In *Weaver*, a federal district court ruled that Missouri could not limit Medicaid coverage for the drug AZT within federal guidelines published by the Food and Drug Administration for treatment of AIDS victims, as federal Medicaid regulations required coverage of medically necessary treatments as determined by the patient's physician. *See generally* Buchanon, *State Medical Coverage of AZT and AIDS-Related Policies*, 7 AM. J. PUB. HEALTH 432 (1988).

128. 42 U.S.C. § 1396b(i) (1988). *See* Ellis v. Patterson, 859 F.2d 52 (8th Cir. 1988); Todd v. Sorrell, 841 F.2d 87 (4th Cir. 1988).

129. *See* MEDICAID SOURCE BOOK, *supra* note 30, at 91-114; K. ERDMAN & S. WOLFE, *supra* note 16.

130. MEDICAID SOURCE BOOK, *supra* note 30, at 125, 131.

131. *Id.* at 128.

132. *Id.* at 135-37.

133. *Id.* at 137-38.

134. 42 U.S.C. § 1396a(a)(2) & (30)(A) (1988); 42 C.F.R. pt. 447 (1988). *See* MEDICAID SOURCE BOOK, *supra* note 30, at 124-48.

135. 42 C.F.R. § 447.15 (1988).

136. 42 U.S.C. § 1396o (1988). *See* Kinney, *Medicaid Copayments: A Bitter Pill for the Poor*, 10 J. LEGIS. 213 (1983).

137. 42 C.F.R. § 447.200 (1988).

138. *Id.* at § 447.253(1).

Payment levels must also be sufficient to ensure that there are enough providers to serve Medicaid beneficiaries.¹³⁹ This requirement has been especially difficult for states to meet with respect to physician services.¹⁴⁰ State payment rates for physicians have consistently been so low that access to health care services among many groups, particularly pregnant women and children, has been compromised.¹⁴¹ Medicaid payment methodologies have also decreased hospital participation in Medicaid, particularly since 1981.¹⁴²

Medicaid rates for hospitals and skilled nursing facilities cannot exceed Medicare rates, but must be "reasonable and adequate" to meet the costs of "efficiently and economically operated facilities."¹⁴³ This requirement has proven controversial, particularly in the early 1980s when states tightened payment rates as evidenced by the litigation of hospitals, nursing homes, and their associations.¹⁴⁴ Reiterating that Congress has endeavored to place the responsibility on states to determine whether state Medicaid payment methodologies for institutional providers met these criteria, the Supreme Court in *Virginia Hospital Association v. Wilder*¹⁴⁵ ruled that the "Boron Amendment" authorizing

139. *Id.* at § 447.204.

140. See, e.g., Fossett & Peterson, *Physician Supply and Medicaid Participation: The Causes of Market Failure*, 27 MED. CARE 386 (1989); Perloff, Kletke & Neckerman, *Physicians' Decisions to Limit Medicaid Participation: Determinants and Policy Implications*, 12 J. HEALTH POL., POL'Y & L. 221 (1987); Perloff, Kletke & Neckerman, *Recent Trends in Pediatrician Participation in Medicaid*, 24 MED. CARE 749 (1986); Garner, *Increasing Clients' Access to Medicaid Providers: New Developments*, 18 CLEARINGHOUSE REV. 1269 (1985); Mauskopf, Rodgers & Dobson, *State Medicaid Program Controls and Health Care Services Utilization*, 7 HEALTH CARE FIN. REV. 16 (1985); Holahan, *Paying for Physician Services in State Medicaid Programs*, 5 HEALTH CARE FIN. REV. 99 (1984).

141. See D. LEWIS-IDEMA, *INCREASING PROVIDER PARTICIPATION* (Nat'l Governors Ass'n 1988).

142. See J. HOLAHAN, *THE IMPACT OF ALTERNATIVE MEDICAID HOSPITAL PAYMENT SYSTEMS ON HOSPITALS' MEDICAID REVENUES, ADMINISTRATIONS, AND LENGTHS OF STAY* (1987); Holahan, *The Impact of Alternative Hospital Payment Systems on Medicaid Costs*, 25 INQUIRY 517 (1988); Mauskopf, Rodgers & Dobson, *supra* note 140. Indeed, the American Hospital Association reported that Medicaid admissions accounted for 60 percent of the 1.6 percent drop in hospital admissions for all persons under age 65 from 1981 and 1982, a significant statistic since Medicaid accounted for only 10.5 percent of all hospital admissions for this age group during this period. AM. HOSP. ASS'N, OFF. OF PUB. POLICY ANALYSIS, *REASONS FOR THE DOWNTURN IN UNDER 65 ADMISSIONS* (Policy Brief No. 52, 1984).

143. 42 U.S.C. § 1396a(a)(13)(A) (1988). In the 1980s, Congress revised federal requirements for state payment methodologies for institutional providers, enabling states to depart from cost reimbursement to more innovative and presumably cost saving payment methodologies based on the criterion that payment rates be "reasonable and adequate" to meet the costs of "efficiently and economically operated facilities." *Id.* In the "Boron Amendment" of the Omnibus Reconciliation Act of 1980, § 962(b), Pub. L. No. 96-499, 94 Stat. 2651, Congress established this standard for nursing homes. The following year, Congress extended this requirement for hospitals. OBRA '81 § 2173, 95 Stat. 357, 808-09 (1981).

144. See Kennedy, *The Medicaid Program: Vague Standards Breed Litigation*, 28 ST. LOUIS U. L.J. 351 (1984); KINNEY, *HOSPITAL CHALLENGES TO STATE MEDICAID PAYMENT RATES SINCE THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981* (Am. Hosp. Ass'n, 1984). See, e.g., *Temple Univ. v. White*, 429 F. Supp. 1093 (E.D. Pa. 1990). *Washington St. Hosp. Ass'n v. Washington*, [1987-2 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 36,352 (W.D. Wash. May 18, 1987); *Wisconsin Hosp. Ass'n v. Reivitz*, 820 F.2d 863 (7th Cir. 1987); *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653 (4th Cir. 1989), *aff'd sub nom.* *Virginia Hosp. Ass'n v. Wilder*, 110 S. Ct. 2510 (1990); *West Virginia Univ. Hosp., Inc. v. Casey*, 885 F.2d 11 (3rd Cir. 1989); *Friedman v. Perales*, 668 F. Supp. 216 (S.D.N.Y. 1989), *aff'd*, 841 F.2d 47 (2d Cir. 1988); *Colorado Health Care Ass'n v. Colorado Dep't of Social Services*, 598 F. Supp. 1400 (D. Colo. 1984), *aff'd*, 842 F.2d 1158 (10th Cir. 1988); *Hillhaven Corp. v. Wisconsin Dep't of Health and Social Services*, 634 F. Supp. 1313 (E.D. Wisc. 1986); *Illinois Health Care Ass'n, Inc. v. Quern*, [1983-1 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 32,396 (N.D. Ill. 1983); *Nebraska Health Care Ass'n, Inc. v. Dunning*, 575 F. Supp. 176 (D. Neb. 1983).

145. 110 S. Ct. 2510 (1990), *aff'g sub nom.* *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653 (4th Cir. 1989).

states to adopt "reasonable and adequate" payment rates created a substantial federal right inuring to the benefit of providers and thus was enforceable under 42 U.S.C. § 1983, which authorizes a private cause of action for the "deprivation of any rights" secured by federal laws.¹⁴⁶

State payment rates must meet the special needs of institutions serving a disproportionate share of the poor,¹⁴⁷ another requirement that has proven extremely controversial, particularly in recent years.¹⁴⁸ This requirement was initially enacted in the Omnibus Budget Reconciliation Act of 1981¹⁴⁹ but was never fully or effectively implemented.¹⁵⁰ Then, in the Omnibus Budget Reconciliation Act of 1987, Congress established minimum criteria for disproportionate share hospitals, required states to make payment adjustments to these hospitals, and also prohibited HCFA from limiting the amount of these payment adjustments.¹⁵¹

States can contract with HMOs to provide Medicaid services for a prepaid, set premium for each enrollee but at levels that assure accessible services.¹⁵² Since passage of the Omnibus Budget Reconciliation Act of 1981, which contained several provisions facilitating the use of HMOs and other managed care systems for Medicaid beneficiaries,¹⁵³ states have experimented extensively with serving their Medicaid populations through HMOs and other prepaid, case management approaches.¹⁵⁴ In the early 1980s, HCFA conducted an extensive evaluation of these initiatives.¹⁵⁵ It is noteworthy that there has been considerable concern about the ability of states to transfer risk and responsibility for the treatment of Medicaid beneficiaries to HMOs and other private organizations sponsoring case management programs and the resulting lack of public control over the quantity and quality of services provided to Medicaid beneficiaries in these systems.¹⁵⁶

146. 42 U.S.C. § 1983 (1988).

147. 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(h), & 1396r-4 (1988); 42 C.F.R. § 447.253(b)(1)(ii)(A) (1988).

148. See *infra* notes 352-63 and accompanying text.

149. OBRA '81 § 2161 (current version at 42 U.S.C. §§ 1396a(a)(18)(A), 1396a(h) & 1396r-4 (1988)).

150. D. LIPSON, REVISED STATE MEDICAID POLICIES FOR DISPROPORTIONATE SHARE HOSPITALS: A STATUS REPORT (Nat'l Ass'n of Pub. Hosp., 1989).

151. Omnibus Budget Reconciliation Act of 1987 § 4112, Pub. L. No. 100-203, [hereinafter OBRA '87], 101 Stat. 1330-148 to 1330-150 (codified at 42 U.S.C. § 1396a(h) (1988)).

152. 42 U.S.C. § 1396b(m) (1988); 42 C.F.R. §§ 417.104-417.105 (1988).

153. OBRA '81 § 2178, 95 Stat. 357, 813-15 (current version at 42 U.S.C. § 1396n(a)(1)(A) (1988)).

154. Iglehart, *Medicaid Turns to Prepaid Managed Care*, 308 NEW ENG. J. MED. 976 (1983); Dallek, Parks & Waxman, *Medicaid Primary Care Case Management Systems; What We've Learned*, 18 CLEARINGHOUSE REV. 270 (1984); NAT'L GOVERNORS ASS'N, PREPAID AND MANAGED CARE UNDER MEDICAID: OVERVIEW OF CURRENT INITIATIVES (1985); E. NEUSCHLER, PREPAID MANAGED CARE UNDER MEDICAID: OVERVIEW OF CURRENT INITIATIVES (1985); Freund & Neuschler, *Overview of Medicaid Capitation and Case-Management Initiatives*, HEALTH CARE FIN. REV. 21 (1986 Annual Supp.); Anderson & Fox, *Lessons Learned From Medicaid Managed Care Approaches*, 6 HEALTH AFF. 71 (1987); Laudicina & Burwell, *A Profile of Medicaid Home and Community-Based Care Waivers, 1985: Findings of a National Survey*, 13 J. HEALTH POL., POL'Y & L. 525 (1988).

155. See HEALTH CARE FIN. ADMIN., NATIONWIDE EVALUATION OF MEDICAID COMPETITION DEMONSTRATION (1986); D. FREUND, P. EHRENHAFT & M. HACKBARTH, MEDICAID REFORM: FOUR STUDIES OF CASE MANAGEMENT (1984).

156. See, e.g., Bovbjerg, Held & Pauly, *Privatization and Bidding in the Health-Care Sector*, 6 J. POL'Y ANALYSIS AND MANAGEMENT 648 (1987); Rosenblatt, *Medicaid Primary Care Case Management, The Doctor-Patient Relationship, and the Politics of Privatization*, 36 CASE W. RES. L. REV. 915 (1985-86); Freund, *The*

D. Waiver of Program Requirements

Waivers play an important role in the Medicaid program by permitting states to experiment with different approaches to financing and delivering health care services and also to meet the particular needs of special groups of beneficiaries. The most important waiver authorities are for primary care case management systems¹⁵⁷ and home and community based long-term care.¹⁵⁸ In primary care case management systems, states contract with certain providers and require beneficiaries to get only services provided or authorized by these providers and mandate case management for the care of individual beneficiaries.¹⁵⁹ With the home and community based long-term care waivers, states can provide home and community-based long-term care services to individuals who would otherwise require care in a skilled nursing facility or an intermediate care facility.¹⁶⁰ Also, under this waiver authority, states can obtain Medicaid funding for some social services that would not otherwise be covered under the Medicaid program.¹⁶¹ Nevertheless, expenditures for services at home cannot exceed those that would have been incurred in an institution.¹⁶²

In the Tax Equity and Fiscal Responsibility Act of 1982, Congress authorized another waiver authority which gives states the option of extending Medicaid eligibility to disabled children living at home who would qualify for SSI if institutionalized.¹⁶³ This waiver was expanded in 1985 to include all ventilator dependent children who would qualify for SSI and Medicaid if institutionalized but would lose Medicaid eligibility if treated at home because of the deeming of their parents' income to them.¹⁶⁴ Under these authorities, states may waive the deeming rules and pay for support services to keep the children in the home, at costs lower than would be incurred if the child was institutionalized.

HCFA has also established a separate category of so-called "model waivers" to address the needs of individual children who might qualify for Medicaid only if institutionalized.¹⁶⁵ States must keep the number of persons served under a model waiver relatively small; otherwise the state must use the waiver author-

Private Delivery of Medicaid Services: Lessons for Administrators, Providers, and Policymakers, 9 J. AMBULATORY CARE MGMT. 54 (1986).

157. 42 U.S.C. § 1396n(b)(1) (1988).

158. 42 U.S.C. § 1396n(c) (1988).

159. See SENATE COMM. ON FINANCE, 98TH CONG., 2D SESS., NEW APPROACHES TO PROVIDING HEALTH CARE TO THE POOR: MEDICAID FREEDOM OF CHOICE WAIVER ACTIVITIES (Comm. Print 1984).

160. MEDICAID SOURCE BOOK, *supra* note 30, at 156-59.

161. *Id.* at 157.

162. 42 U.S.C. § 1396n(c)(2)(D) (1988) (for the mentally retarded) and 42 U.S.C. § 1396n(d)(5) (1988) (for the elderly).

163. Tax Equity and Fiscal Responsibility Act of 1982 § 134, Pub. L. No. 97-248 [hereinafter TEFRA], 96 Stat. 324, 375 (current version at 42 U.S.C. § 1396a(a)(2)(B) & (C) (1988)). These waiver authorities for seriously ill children were inspired by the highly publicized case of a ventilator dependent child, Katie Beckett. Katie spent the first three years of her life in an institution because her family could not afford to treat her at home. President Ronald Reagan intervened at the beginning of his administration to obtain Medicaid eligibility for her. See Connell, *HHS Waives Rules So Katie Can Have Medicaid at Home*, Wash. Post, Nov. 13, 1981, at A20; *Girl to be Treated at Home*, N. Y. Times, Nov. 13, 1981, at A12, col. 5.

164. Consolidated Budget Reconciliation Act of 1985 § 9502, Pub. L. No. 99-272, [hereinafter COBRA], 100 Stat. 82, 202 (current version at 42 U.S.C. § 1396a(e)(3)(C) (1988)).

165. MEDICAID SOURCE BOOK, *supra* note 30, at 159.

ity enacted in TEFRA for children who would be eligible for Medicaid only if institutionalized and would have to include all such children in the state.¹⁶⁶

These waivers essentially expand Medicaid eligibility to some catastrophically ill children of middle class parents. The model waivers are particularly troublesome because they are triggered primarily by the application of parents. The waivers greatly depend on the parents' ability to bring political pressure on state agencies and HCFA to secure Medicaid eligibility for the child. Model waivers, by definition, are not accorded to every child in need in the state. These waiver authorities have not been used extensively since 1981.

E. *Appeal Procedures*

A state Medicaid plan must provide for "granting an opportunity for fair hearing before the [s]tate agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness."¹⁶⁷ Federal Medicaid regulations establish procedures for hearings involving the suspension, termination, or reduction of services. Specifically, the state plan may provide a hearing before the state agency or an evidentiary hearing at the local level with the right to appeal to the state agency.¹⁶⁸ Federal law also mandates specific appeal procedures for nursing home beneficiaries dissatisfied with their care or treatment in long-term care facilities¹⁶⁹ and for disputes over income and resource determinations regarding eligibility for long-term care services.¹⁷⁰ Federal Medicaid regulations require that states provide appeal or exception procedures for providers to obtain administrative review of state Medicaid payment rates.¹⁷¹

Further, when a state agency takes any action affecting an individual's claim for Medicaid benefits, the state agency must give notice and include reasons for the action and an explanation of the applicable law and regulations as well as the procedures to be invoked in the hearing.¹⁷² Several cases have addressed notice issues and, indeed, notice seems to be the predominant issue regarding procedural due process raised in litigation since 1981.¹⁷³

166. *Id.*

167. 42 U.S.C. § 1396a(a)(3) (1988); 42 C.F.R. § 431.205 (1988).

168. *Id.* at § 431.205.

169. 42 U.S.C. § 1396r(c)(1)(A)(vi) (1988).

170. 42 U.S.C. § 1396r(e)(7)(F) (1988).

171. 42 C.F.R. § 447.253(c) (1988).

172. *Id.* at §§ 431.206 & 431.210.

173. In *Ortiz v. Eichler*, 794 F.2d 889 (3d Cir. 1986), the Third Circuit ruled that procedural due process required that the notice of termination to a Medicaid beneficiary must contain the specific calculations used to arrive at the decision to terminate benefits and that the state agency could not rely on adverse statements from declarants who were not available for cross-examination or confrontation at the termination hearings. In *Easley v. Arkansas Dep't of Human Services*, 645 F. Supp. 1535 (E.D. Ark. 1986), a federal district court ruled that a Medicaid handbook with a toll free telephone number given to Medicaid beneficiaries upon entry into the Medicaid program was insufficient notice of a requirement that the state must authorize payment for medical services before they are obtained.

IV. MEDICAID RULE AND POLICY MAKING

Since 1981, problems have developed with Medicaid rule and policy making at the federal level and implementation of these policies at the state level. It is fair to say that the large number of congressionally mandated changes in the Medicaid program since 1981, as well as program changes initiated by HCFA, have precipitated many of these problems. This section reviews these changes and HCFA's rule and policy making activities; it then specifically analyzes the problems with HCFA rule and policy making for the Medicaid program.

A. *Congessionally Mandated Changes in the Medicaid Program*

In 1981, Congress, following an initiative from the new, popular, and ideologically conservative Reagan administration, enacted fundamental changes in the Medicaid program. Basically, the Omnibus Budget Reconciliation Act of 1981 (OBRA '81) limited the federal financial commitment to the Medicaid program while according states greater flexibility to structure their Medicaid programs to achieve savings.¹⁷⁴ Specifically, OBRA '81 reduced federal Medicaid payments to states by 3 percent in fiscal year 1982, and provided for further reductions in later years which Congress subsequently repealed.¹⁷⁵ OBRA '81 accorded states greater flexibility in setting eligibility and coverage policy,¹⁷⁶ methods for paying hospitals,¹⁷⁷ and requirements for HMOs serving Medicaid recipients.¹⁷⁸ In addition, Congress gave HCFA authority to grant waivers of program requirements to establish case management systems and home and community-based care for some Medicaid beneficiaries.¹⁷⁹ As a result of this new flexibility, the 1980s witnessed great changes in state Medicaid programs including the adoption of innovative reforms in the way health care services are delivered to the Medicaid population.¹⁸⁰

In subsequent years, Congress enacted many more changes in the Medicaid program as part of its effort to reduce the federal budget deficit. The federal budget deficit reached a startling \$110.6 billion in fiscal year 1982, the year following passage of the cost containment measures of OBRA '81.¹⁸¹ The Medi-

174. OBRA '81 §§ 2171-2174, 95 Stat. 357, 807-09 (codified at scattered sections of §§ 1396-1396s (1988)). See R. BOVBERG & J. HOLAHAN, *MEDICAID IN THE REAGAN ERA: FEDERAL POLICY AND STATE CHOICES* (1982); J. HOLAHAN, *THE EFFECTS OF THE 1981 OMNIBUS RECONCILIATION ACT ON MEDICAID* (1985); Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U.L. REV. 1 (1983); Rowland, Lyons & Edwards, *supra* note 35.

175. OBRA '81 § 2161, 95 Stat. 357, 803-05 (codified at 42 U.S.C. § 1396b (1988)), *repealed*, Pub. L. No. 97-248, § 137(a)(2) (1982).

176. OBRA '81 §§ 2171-72, 95 Stat. 357, 807-08 (current version at 42 U.S.C. §§ 1396a(a)(10) & 1396a(b) (1988)). See generally I. HILL, *MEDICAID ELIGIBILITY: A DESCRIPTIVE REPORT OF OBRA, TEFRA, AND DEFRA PROVISIONS AND STATE RESPONSES* (Nat'l Governors Ass'n, 1984).

177. OBRA '81 § 2173, 95 Stat. 357, 808-09 (current version at 42 U.S.C. § 1396a(a)(13) (1988)). See *supra* note 143 and accompanying text.

178. OBRA '81 § 2178, 95 Stat. 357, 813-15 (current version at 42 U.S.C. § 1396a(e)(2) (1988)).

179. OBRA '81 § 2176, 95 Stat. 357, 812-13 (current version at 42 U.S.C. § 1396n(c) (1988)). See *supra* notes 157-66 and accompanying text.

180. See Omenn, *Lessons from a Fourteen-State Study of Medicaid*, 6 HEALTH AFF. 118 (1987). See *supra* notes 153-56 and accompanying text.

181. EXECUTIVE OFF. OF THE PRESIDENT, OFF. OF MANAGEMENT AND BUDGET, *BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1984 M-11* (1983).

caid program became an extremely attractive target for budget cutting. For many other parts of the federal budget, e.g., defense and Social Security income insurance programs (which comprise nearly half of budgetary expenditures),¹⁸² and interest on the national debt, were unavailable for reductions either as a political or practical matter.

In TEFRA, picking up on initiatives of the Reagan Administration,¹⁸³ Congress enacted more changes in the Medicaid program. TEFRA expanded state authority to charge co-payments to Medicaid beneficiaries,¹⁸⁴ impose liens on the homes of institutionalized beneficiaries, and levy penalties for transferring homes for less than fair market value before applying for Medicaid benefits.¹⁸⁵ Congress also established optional coverage of home care for disabled children who would qualify for Medicaid only if institutionalized.¹⁸⁶ Finally, the other major change in TEFRA was a six-month moratorium on HCFA's efforts to promulgate rules to deregulate nursing homes,¹⁸⁷ a very controversial initiative of the Reagan administration discussed below.¹⁸⁸

In the mid-1980s, Congress became especially active in mandating changes in the Medicaid program. The Democrats acquired more congressional representatives in the 1982 and 1984 general elections, and gained control of the Senate in the 1986 election. The Democratic Party had a markedly different vision of the federal government's obligation to the poor compared to the Republican administration in power. The tenor of congressional legislation changed from pushing financial and programmatic responsibility to the states and containing federal costs to expanding program benefits with a view toward equalizing treatment of similarly situated groups across states and imposing greater regulatory authority over providers. The Reagan administration opposed many of these benefit expansions, in part, because of their negative impact on the federal budget.

Specifically, in the Deficit Reduction Act of 1984 (DEFRA), Congress enacted optional coverage of some pregnant women and children not receiving Medicaid as categorically needy beneficiaries and mandated coverage of all children meeting AFCD income and resource regardless of whether they were receiving AFDC.¹⁸⁹ The impetus for this program expansion was disturbing evidence that the infant mortality rate was not declining, especially for black infants.¹⁹⁰ Interestingly, Congress made this expansion effective regardless of

182. These two categories comprised 47 percent of estimated budget outlays in fiscal year 1989. BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1990, *supra* note 5, at 10-30 & 10-36.

183. EXECUTIVE OFF. OF THE PRESIDENT, OFF. OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1983 5-131 (1982).

184. TEFRA § 131, 96 Stat. 324, 367-70 (current version at 42 U.S.C. §§ 1396a(a)(14) & 1396o (1988)). See *supra* note 136 and accompanying text.

185. TEFRA § 132, 96 Stat. 324, 370-73 (current version at 42 U.S.C. § 1396a(a)(18) & 1396p (1988)).

186. TEFRA § 134, 96 Stat. 324, 375 (current version at 42 U.S.C. § 1396a(e)(3) (1988)). See *supra* note 163 and accompanying text.

187. TEFRA § 135, 96 Stat. 324, 375.

188. See *infra* notes 190, 234-36 and accompanying text.

189. Deficit Reduction Act of 1984 § 2361, Pub. L. No. 98-369 [hereinafter DEFRA], 98 Stat. 494, 1104 (current version at 42 U.S.C. § 1396a(a)(10)(A) (1988)).

190. See *supra* note 36 and accompanying text.

whether HCFA had promulgated implementing regulations, beginning a practice that has accompanied congressionally mandated changes in the Medicaid program ever since.¹⁹¹ DEFRA also required that states engage in medical review of services provided to Medicaid beneficiaries to ensure that services provided were medically necessary.¹⁹²

In the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Congress continued the expansion of optional coverage of pregnant women and children initiated in DEFRA.¹⁹³ COBRA established optional hospice benefits,¹⁹⁴ case management services,¹⁹⁵ and expanded coverage of ventilator dependent children who would qualify for Medicaid only if institutionalized.¹⁹⁶ In addition, COBRA required HCFA to promulgate regulations and other requirements for intermediate care facilities for the mentally retarded,¹⁹⁷ and tightened requirements for HMOs and similar organizations serving Medicaid beneficiaries.¹⁹⁸ COBRA also required that, if a state elects to cover organ transplants, it must develop written coverage criteria and standards.¹⁹⁹

Congress mandated that many of the benefit expansions in COBRA be effective immediately and that states implement many changes whether or not HCFA had promulgated implementing regulations. For example, states had to implement the expanded benefits for children and pregnant women regardless of whether HCFA implemented regulations.²⁰⁰ (It was two years before HCFA promulgated final rules on this subject.)²⁰¹ Congress also specifically required that HCFA promulgate regulations revising standards for the intermediate care facilities for the mentally retarded within sixty days of enactment.²⁰² Again, HCFA issued these regulations more than two years later.²⁰³

The following year, Congress again enacted major changes to the Medicaid program in the Omnibus Budget Reconciliation Act of 1986 (OBRA '86).²⁰⁴ Congress further expanded optional coverage for poor pregnant women, chil-

191. DEFRA § 2361(d)(1), 98 Stat. 494, 1104.

192. DEFRA § 2368, 98 Stat. 494, 1109-10 (current version at 42 U.S.C. §§ 1396a(a)(26) & 1396a(a)(31) (1988)).

193. COBRA § 9501, 100 Stat. 82, 201-02 (current version at 42 U.S.C. §§ 1396a(a)(10)(D) & (e) (1988)).

194. COBRA § 9505, 100 Stat. 82, 208-09 (current version at 42 U.S.C. §§ 1396a(a)(10) & (13) & 1396d(a) (1988)).

195. COBRA § 9508, 100 Stat. 82, 210-11 (current version at 42 U.S.C. § 1396n(g) (1988)).

196. COBRA § 9510, 100 Stat. 82, 212 (current version at 42 U.S.C. § 1396a(a)(10) (1988)).

197. COBRA § 9514, 100 Stat. 82, 213 (1986).

198. COBRA § 9517, 100 Stat. 82, 215-16 (current version at 42 U.S.C. § 1396b(m)(2) (1988)).

199. COBRA § 9507(a), 100 Stat. 82, 210 (current version at 42 U.S.C. § 1396b(i)).

200. COBRA § 9501(d)(1), 100 Stat. 82, 202.

201. 42 C.F.R. §§ 435.115, 435.301, 436.2, 436.114, 436.301 (1988). See *infra* notes 251-53 and accompanying text.

202. COBRA § 9514, 100 Stat. 82, 213.

203. Health Care Fin. Admin., Conditions for Intermediate Care Facilities for the Mentally Retarded, 53 Fed. Reg. 20,448 (June 3, 1988) (codified at 42 C.F.R. Pts. 431, 435, 440, 442 and 483); Standards for Intermediate Care Facilities/Mentally Retarded, 51 Fed. Reg. 7520 (Mar. 4, 1986).

204. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509 [hereinafter OBRA '86], 100 Stat. 1874 (current version at scattered sections of 42 U.S.C.S. (Law. Co-op. 1985 & Supp. 1990)).

dren and infants,²⁰⁵ including an optional presumptive eligibility period for pregnant women.²⁰⁶

OBRA '86 authorized states, at their option, to make all Medicaid benefits available to the elderly and disabled with incomes up to 100 percent of the federal poverty level and meeting SSI or, if more generous, state resource standards.²⁰⁷ OBRA '86 also authorized states to pay Medicare cost-sharing expenses for poor Medicare beneficiaries.²⁰⁸ OBRA '86 modified the Medicaid waiver authorities²⁰⁹ and adopted several other measures to enhance the quality and efficiency of the state Medicaid programs.²¹⁰

Again, Congress mandated implementation of most provisions of OBRA '86 either immediately or within fiscal year 1987. Congress also mandated implementation of benefit expansions and some other changes without regard to whether HCFA had promulgated regulations to implement the provision.²¹¹ Further, Congress amended the statutory language regarding effective dates for program expansions in COBRA to facilitate implementation of these expansions.²¹²

In the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress enacted expanded optional coverage for infants, children and mothers and extensive reforms for nursing homes that participated in the Medicare and Medicaid programs.²¹³ These reforms followed publication of a major study of the quality of care in nursing homes by the prestigious Institute of Medicine.²¹⁴ HCFA had asked the Institute of Medicine to conduct this study after a firestorm of protest in Congress and among beneficiary advocates over HCFA's 1982 proposed rule to change procedures for monitoring nursing home compliance with Medicare and Medicaid conditions of participation.²¹⁵ This Notice of

205. OBRA '86 § 9401, 100 Stat. 1874, 2050-52 (current version at 42 U.S.C.S. §§ 1396a(a)(10)(A)(ii)(IX) & 1986a(L) (Law. Co-op. 1985 & Supp. 1990)).

206. OBRA '86 § 9407, 100 Stat. 1874, 2058-60 (current version at 42 U.S.C. §§ 1396a(a)(47) & 1396r-1 (1988)).

207. OBRA '86 § 9402, 100 Stat. 1874, 2052-53 (current version at 42 U.S.C. § 1396a(m) (1988)).

208. OBRA '86 § 9403, 100 Stat. 1874, 2053-56 (current version at 42 U.S.C.S. §§ 1396a(a)(10)(E) (Law. Co-op. 1985 & Supp. 1990) & 42 U.S.C. § 1396d (1988)).

209. OBRA '86 § 9411, 100 Stat. 1874, 2061-62 (current version at 42 U.S.C. § 1396n(c) (1988)).

210. OBRA '86 §§ 9431-9436, 100 Stat. 1874, 2066-71 (codified as amended at scattered sections of 42 U.S.C. §§ 1396-1396s (1988)).

211. OBRA '86 § 9401(f), 100 Stat. 1874, 2052 (optional benefit for pregnant women, infants and children); *Id.* at § 9402(c), 100 Stat. 1874, 2052-53 (optional coverage of all Medicaid benefits for elderly and disabled poor); *Id.* at § 9403(h), 100 Stat. 1874, 2056 (optional coverage of Medicare cost-sharing expenses for poor Medicare beneficiaries); *Id.* at § 9404(c)(1), 100 Stat. 1874, 2057 (Medicaid eligibility for qualified severely impaired individuals); *Id.* at § 9406(c)(1), 100 Stat. 1874, 2058 (payment for aliens under Medicaid); *Id.* at § 9407(d), 100 Stat. 1874, 2060 (presumptive eligibility for pregnant women); *Id.* at § 9431(c), 100 Stat. 1874, 2066 (independent quality review for HMO services).

212. OBRA '86 § 9435(d), 100 Stat. 1874, 2070, *amending* COBRA §§ 9505(e); 9508(b); 9510(b) & 9511(b), 100 Stat. 82, 209-13 (codified as amended at scattered sections of 42 U.S.C. §§ 1396-1396s (1988)).

213. OBRA '87 §§ 4201-4214, 101 Stat. 1330 (current version 42 U.S.C.S. 1396r (Law. Co-op. 1985 & Supp. 1990)).

214. INST. OF MED., *IMPROVING THE QUALITY OF CARE IN NURSING HOMES* (1986).

215. Survey and Certification of Health Care Facilities, 47 Fed. Reg. 23,407-14 (to be codified at 42 C.F.R. § 490.1-490.60, 405.1901-405.1913, 431.610, 441.15, 442.1-442.112) (proposed May 27, 1982). *See* SUBCOMM. ON HEALTH AND THE ENVIRONMENT OF THE HOUSE COMM. ON ENERGY AND COMMERCE, 100TH CONG., 1ST SESS., *MEDICARE AND MEDICAID HEALTH BUDGET RECONCILIATION AMENDMENTS OF 1987 76-77* (Comm. Print. 1987) [hereinafter *HEALTH BUDGET RECONCILIATION AMENDMENTS OF 1987*].

Proposed Rule Making (NPRM) was part of a controversial initiative of the Reagan administration to deregulate the nursing home industry.

The Institute of Medicine found serious problems with the quality of care and treatment of patients in nursing homes and reported: "There is a broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation."²¹⁶ The Institute of Medicine proceeded to recommend major reforms in the conditions of participation that establish standards for nursing homes serving Medicare and Medicaid beneficiaries, the survey and certification process by which HCFA and states monitor compliance with conditions of participation and the enforcement procedures by which non-compliance is punished and deterred.²¹⁷ The basic thrust of these recommendations was to focus on regulation to assure that patients actually receive high quality services and respectful treatment rather than just determining whether nursing homes are theoretically able to provide such care and treatment.

The nursing home reforms in OBRA '87 faithfully track the Institute of Medicine's recommendations. OBRA '87 included detailed provisions in the statute about how states and providers should implement the statutory mandates, clearly in an attempt to alleviate the need for detailed guidance that agency rules and policies would customarily provide. There were also detailed requirements for determining the quality of nursing home services²¹⁸ and the rights of nursing home residents.²¹⁹ The nursing home reforms also included changes in the procedures by which States, on behalf of HCFA, survey and certify, nursing homes to ensure that nursing homes are actually meeting the conditions of participation for the Medicare and Medicaid programs.²²⁰ In addition, these reforms established extensive enforcement procedures to ensure compliance with the new requirements for nursing homes.²²¹

For these nursing home reforms, Congress did not explicitly require promulgation of regulations except with respect to one situation where Congress had previously mandated implementing regulations.²²² In this instance, Congress specifically provided that if HCFA did not promulgate regulations within the specified time period, the Secretary of HHS would be deemed to have promulgated the required regulations. In other instances, however, Congress specified that HCFA establish guidelines or criteria for states to follow in implementing the new nursing home requirements.²²³ Further, despite the enormous complexity and extensiveness of these reforms, Congress required states to

216. INST. OF MED., *supra* note 214, at 2.

217. INST. OF MED., *supra* note 214. See HEALTH BUDGET RECONCILIATION AMENDMENTS OF 1987, *supra* note 215, at 77.

218. OBRA '87 § 4211(b), 101 Stat. 1330, 1330-183 (codified at 42 U.S.C. § 1396r(b) (1988)).

219. OBRA '87 § 4211(a), 101 Stat. 1330, 1330-188 (codified at 42 U.S.C. § 1396r(c) (1988)).

220. OBRA '87 § 4212, 101 Stat. 1330, 1330-207 (codified at 42 U.S.C. § 1396r(g) (1988)).

221. OBRA '87 § 4213, 101 Stat. 1330, 1330-213-19 (codified at 42 U.S.C. § 1396r(h) (1988)).

222. OBRA '87 § 4211(f)(7), 101 Stat. 1330, 1330-202 (codified at 42 U.S.C. § 1396r (1988)).

223. OBRA '87 § 4211(f)(3), 101 Stat. 1330, 1330 to 200-01 (codified at 42 U.S.C. § 1396r(f) (1988)).

implement the new survey and certification and also enforcement procedures whether or not HCFA had promulgated regulations.²²⁴

In 1988, the pace of congressionally mandated changes in the Medicaid program slowed. In November 1987, Congress and the Reagan administration negotiated the Bipartisan Budget Agreement outlining measures to reduce the federal budget deficit.²²⁵ Pursuant to this agreement, Congress and the Reagan administration did not propose legislation to achieve savings in the Medicaid program for fiscal year 1989.²²⁶

Nevertheless, in the Medicare Catastrophic Coverage Act of 1988 (MCCA '88), Congress made three major changes in the Medicaid program along with enacting a short-lived catastrophic health insurance benefit for the Medicare program.²²⁷ One change required state Medicaid programs to pay all Part B premiums and co-insurance for indigent Medicare beneficiaries.²²⁸ The second change required states to extend Medicaid coverage to pregnant women and infants whose incomes were at or below 100 percent of the federal poverty level by July 1, 1990.²²⁹ The third change established new requirements for the treatment of income and resources of institutionalized persons whose spouses resided in the community.²³⁰ Congress required implementation of all three of these provisions whether or not HCFA had promulgated regulations.²³¹ It should be noted that Congress retained these Medicaid program changes when it repealed the Medicare catastrophic insurance benefit in 1989.²³² Also, in the Family Support Act of 1988, Congress authorized continuation of Medicaid benefits for one year to persons leaving the AFDC program to facilitate the transition of such families to the work force without fear of losing health insurance coverage.²³³

In the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Congress made several changes in the Medicaid program to assure improved maternal and child health services.²³⁴ Specifically, Congress mandated that, effective

224. OBRA '87 § 4214, 101 Stat. 1330, 1330-219 (codified at 42 U.S.C. § 1396r(g) (1988)).

225. EXECUTIVE OFF. OF THE PRESIDENT, OFF. OF MANAGEMENT AND BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1989, 2b-1 to 2b-2 (1988).

226. *Id.* at 5-108.

227. MCCA '88 §§ 301-303, Pub. L. No. 100-360, 102 Stat. 683, 748-64 (codified at scattered subsections of 42 U.S.C.S. § 1396) (Law. Co-op. 1985 & Supp. 1990).

228. MCCA '88 § 301, 102 Stat. 683, 748-50 (codified at 42 U.S.C.S. §§ 1396a(a)(10)(E) & 1396d(p) (Law. Co-op. 1985 & Supp. 1990)).

229. MCCA '88 § 302, 102 Stat. 683, 750-51 (codified at 42 U.S.C.S. § 1396a(a)(10) & 1396a(1)) (Law. Co-op. 1985 & Supp. 1990).

230. MCCA '88 § 303, 102 Stat. 683, 754-64 (codified at 42 U.S.C.S. § 1396r-s) (Law. Co-op. 1985 & Supp. 1990).

231. MCCA '88 § 301(h), 102 Stat. 683, 748-50 (required Medicaid buy-in of premiums and cost-sharing for indigent Medicare beneficiaries); *Id.* at § 302(f)(1), 102 Stat. 683, 753 (coverage and payment for pregnant women and infants with incomes below the poverty line); *Id.* at §§ 303(g)(1)(A), (2)(A) & (3), 102 Stat. 683, 763-64 (protection of income and resources of couple for maintenance of community spouse).

232. Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, 103 Stat. 1979 (codified at scattered subsections of U.S.C.S. § 1395) (Law. Co-op. 1985 & Supp. 1990).

233. MCCA '88 § 303, Pub. L. No. 100-485, 102 Stat. 2343, 2385-93 (codified as amended at 42 U.S.C.S. § 1396r-6) (Law. Co-op. 1985 & Supp. 1990).

234. OBRA '89 §§ 6401-6407, 103 Stat. 2106, 2258-67 (current version at scattered sections of 42 U.S.C.S. §§ 1396-1396s) (Law. Co-op. 1985 & Supp. 1990).

April 1990, state Medicaid programs must cover children under seven and born after 1983 and pregnant women whose family income is at or below 133 percent of the federal poverty level.²³⁵ Also, OBRA '89 required states to reestablish early and periodic screening, diagnostic and treatment (EPSDT) services for children on Medicaid.²³⁶ Several provisions of OBRA '89 called for reforms in the payment levels for pediatricians, obstetricians, nurse practitioners as well as community and migrant health centers to assure better access to these services for poor women and children.²³⁷ As with earlier congressional mandates, Congress required implementation whether or not HCFA promulgated regulations.²³⁸

In OBRA '90, Congress made several major changes in the Medicaid program, including some significant benefit expansions for older children.²³⁹ Specifically, OBRA '90 contained extensive new rebate requirements for Medicaid and mandated drug use review for outpatient prescription drugs for Medicaid beneficiaries.²⁴⁰ Also, OBRA '90 modified some requirements for nursing home reform and specifically prohibited HCFA from taking compliance actions against a state regarding several nursing reform requirements, e.g., preadmission screening and annual resident review, before HCFA issues implementing regulations or guidelines.²⁴¹

B. *Problems with Medicaid Rule and Policy Making*

Since 1981, one fundamental problem with rule and policy making in the Medicaid program has emerged: HCFA's inability to promulgate policy and rules, whether procedural, interpretative or legislative, in a timely and expeditious manner. In many cases, HCFA has provided states with no rules or policies at all to implement a congressionally mandated change by a deadline or even approved a state plan amendment which would allow states to implement a legislative change without a subsequent disallowance action or error rate penalty.

Clearly HCFA, and the states, have had difficulty digesting congressionally mandated changes in the Medicaid program since 1981. As one HHS official commented, statutory changes are "outrunning [HCFA's] physical ability to keep up." Indeed, HCFA experienced a decrease in personnel in the 1980s to

235. OBRA '89 § 6401, 103 Stat. 2106, 2258 (current version at 42 U.S.C.S. § 1396a(a)(10)(A)) (Law. Co-op. 1985 & Supp. 1990).

236. OBRA '89 § 6403, 103 Stat. 2106, 2262-64 (codified at 42 U.S.C.S. § 1396(d)(r) & 1396a(a)(30)) (Law Co-op. 1985 & Supp. 1990).

237. OBRA '89 §§ 6402, 6405-6406, 103 Stat. 2106, 2260-65 (codified at scattered sections of 42 U.S.C.S. §§ 1396-1396s) (Law. Co-op. 1985 & Supp. 1990). Covered services include obstetric and pediatric services, federally qualified health center services and nurse practitioner services.

238. OBRA '89 § 6401(c), 103 Stat. 2106, 2258 (mandatory coverage of certain low income pregnant women and children); § 6402(d)(2)(A), 103 Stat. 2106, 2261 (payment for obstetric and pediatric services); § 6403(e), 103 Stat. 2106, 2264 (EPSDT defined); § 6404(d), 103 Stat. 2106, 2264 (payment for federally qualified health center services); § 6406(b), 103 Stat. 2106, 2266 (required coordination with Special Supplemental Food Program for Women and Children).

239. OBRA '90, §§ 4601 & 4603, 104 Stat. 1388 (to be codified at 42 U.S.C. § 1396a(a)(10)(A) & 1396a(e)).

240. OBRA '90, § 4401, 104 Stat. 1388 (to be codified at 42 U.S.C. § 1396b(i)).

241. OBRA '90, § 4801, 104 Stat. 1388 (to be codified at 42 U.S.C. § 1396r).

such a degree that, in OBRA '89, Congress mandated a study of HCFA's personnel problems and needs by the National Academy of Public Administration.²⁴²

It is fair to say that the congestion in the process for making rules and policies at both the federal and state level has been aggravated by Congress' practice of requiring states and HCFA to implement legislative changes by specific dates regardless of whether HCFA has promulgated regulations to implement the program change. Yet, Congress has apparently invoked this practice because it concluded that HCFA was too slow in promulgating regulations to implement legislated benefit expansions and other program changes thereby frustrating congressional intent.

1. *HCFA Policy and Rulemaking Since 1981*

a. *Notice-and-Comment Rulemaking*

Since the summer of 1981, HCFA has promulgated over 64 interim final or final rules just for the Medicaid program alone, most of which addressed cost containment or quality control initiatives of HCFA and the Executive Branch.²⁴³ These final rules are in addition to the 43 final or interim final rules that HCFA promulgated for both the Medicare and Medicaid programs.²⁴⁴ While it is beyond the scope of this article to discuss every Medicaid rulemaking, some important developments in legislative rulemaking for the Medicaid program since 1981 are noteworthy.

On September 30 and October 1, 1981, HCFA promulgated eight interim final rules with a comment period to implement the comprehensive changes to the Medicaid program enacted in OBRA '81.²⁴⁵ These rules addressed all of the major changes in the Medicaid program that the Reagan administration had pushed in its 1981 Medicaid reform initiative.²⁴⁶ The rules included the OBRA '81 authorities for waivers regarding primary care case management systems and home and community based services, reductions in federal payments to states, and less restrictive eligibility and coverage criteria and provider payment

242. OBRA '89 § 6223, 103 Stat. 2256.

243. See Appendix A.

244. See Appendix B.

245. Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,971 (1981) (codified at 42 C.F.R. 447.250-447.271 (1981)) (proposed Sept. 30, 1981); Eligibility and Coverage Criteria, 46 Fed. Reg. 47, 984-93 (1981) (codified at scattered sections of 42 C.F.R. 435.1-435.852, 436.2-436.852, 440.210-440.230, 441.10 (1981)) (proposed Sept. 30, 1981); Reductions in Payments to States, 46 Fed. Reg. 48,001-03 (1981) (codified at 42 C.F.R. §§ 433.201-433.217, 45 C.F.R. 201.5 (1981)) (proposed Sept. 30, 1981); Offset Based on Third-Party Liability Recoveries Against Reductions in Medicaid Payments, 46 Fed. Reg. 48,006 (1981) (proposed Sept. 30, 1981); Freedom of Choice; Waivers of and Exceptions to State Plan Requirements, 46 Fed. Reg. 48,527 (1981) (codified at 42 C.F.R. §§ 431.50-431.55, 440.200, 440.250 (1981)) (proposed Oct. 1, 1981); Home and Community-Based Services, 46 Fed. Reg. 48,539-41 (1981) (codified at 42 C.F.R. §§ 431.50, 435.232, 435.735, 435.726, 440.1, 440.170, 440.250 (1981)) (proposed Oct. 1, 1981); Miscellaneous Medicaid Provisions—Increased State Flexibility, 46 Fed. Reg. 48,559-61 (codified at 42 C.F.R. §§ 430.1, 433.10, 435.2, 441.155, 447.200, 447.300, 447.302, 447.304, 447.342, 456.1, 456.60, 456.160, 456.260, 456.360, 456.652 (1981)) (proposed Oct. 1, 1981); Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964 (codified at 42 C.F.R. pts. 447 (1981) (proposed Sept. 30, 1981).

246. See EXECUTIVE OFF. OF THE PRESIDENT, OFF. OF MANAGEMENT AND BUDGET, FISCAL YEAR 1982 BUDGET REVISIONS 70 (1981).

methodologies. This rulemaking effort was truly a tour de force; HCFA promulgated eight complex interim final rules to implement these changes by October 1, 1981 when OBRA '81 was passed only a few months before.

During the next three years, HCFA promulgated 20 final rules for the Medicaid program, many of which implemented Reagan administration initiatives.²⁴⁷ These rules concerned relatively technical matters but included many cost containment and eligibility policy changes. Of particular note, a 1983 final rule addressed deeming of income between spouses necessitated by the Supreme Court's decision in *Schweiker v. Gray Panthers*,²⁴⁸ only eleven months after promulgating the proposed rule.²⁴⁹

By 1985, the pace of legislative rulemaking for the Medicaid program increased. From 1985 through 1988, HCFA promulgated 26 final rules addressing eligibility of beneficiaries, payment of providers, cost containment measures and other more technical matters.²⁵⁰ For most of these final rules, the time between publication of the proposed and final rules was about two years. During this period, HCFA also exhibited delays in promulgating rules to implement congressionally mandated benefit expansions. For example, HCFA promulgated the NPRM to implement the expansion of optional eligibility for infants, children and pregnant women,²⁵¹ which Congress enacted in DEFRA over a year before.²⁵² HCFA promulgated the final rule two years after the NPRM and three years after Congress initiated the eligibility expansion for these groups in DEFRA.²⁵³

By 1989, the pace of rulemaking for the Medicaid program abated. HCFA promulgated five final rules dealing with relatively technical issues, such as eligibility of beneficiaries, payment of providers and state administration.²⁵⁴ Again, the time between publication of the proposed and final rules was often over a year. In the case of legislative rules, HCFA has generally taken more than a year to promulgate final rules. Indeed, often HCFA takes a year from enactment to publish an NPRM. HCFA appears to be fast only in getting out legislative rules that involve relatively technical program changes or measures, e.g., modifications of the error rate penalty procedures, which save federal monies.²⁵⁵ During the early 1980s, HCFA was quite expeditious in promulgating rules to implement Executive Branch initiatives.²⁵⁶ On the other hand, HCFA

247. See Appendix A.

248. 453 U.S. 34 (1981). See *supra* note 111 and accompanying text.

249. 42 C.F.R. §§ 435.121, 435.223, 435.734, 436.711 (1983). Deeming of Income between Spouses: Categorically Needy, 47 Fed. Reg. 31,899 (1982) (codified at 42 C.F.R. §§ 435.121, 435.703, 435.734, 436.711 (proposed July 23, 1982)).

250. See Appendix A.

251. Coverage of Qualified Pregnant Women and Children and Newborn Children, 50 Fed. Reg. 48,102 (1985) (codified at 42 C.F.R. §§ 435.115-435.117, 435.301, 436.2, 436.114, 436.301 (1988)) (proposed Nov. 21, 1985).

252. See *supra* note 189 and accompanying text.

253. Coverage of Qualified Pregnant Women and Children and Newborn Children, 50 Fed. Reg. 48,102 (1985) (codified at 42 C.F.R. §§ 435.115, 435.301, 436.2, 436.114, 436.301) (1988).

254. See Appendix A.

255. See Appendix A.

256. For example, the interim final rule implementing HCFA initiatives regarding HMOs and similar plans was issued thirteen months after the NPRM. 42 C.F.R. §§ 434.1-434.78, 435.3, 435.212, 435.326, 447.361-

was quite slow to implement legislative rules for congressionally mandated benefit expansions,²⁵⁷ taking, for example, three years to promulgate a final rule implementing the initial benefit expansion for mothers and children.²⁵⁸

b. *Use of Interim Final Rulemaking*

Of serious concern is HCFA's use of interim final rules to implement major Medicaid program changes without subsequently issuing final rules. In 1981, HCFA has promulgated seven interim final rules to implement the major changes in the Medicaid program enacted in OBRA '81.²⁵⁹ In only a few instances has HCFA reissued these rules as final rules after accounting for comments. HCFA has continued using interim final rules for promulgating Medicaid policy.²⁶⁰ This practice regarding the use of interim final rules as well as the content of these rules has generated considerable friction between Congress and the Executive Branch.

For example, in 1981, HCFA issued an interim final rule imposing restrictions on the financial criteria that states could use in determining eligibility for so-called "medically needy" persons and creating new authority to eliminate certain children from the program.²⁶¹ These rules contained provisions that were also contained in the Administration's legislative proposals for OBRA '81 that Congress did not incorporate into OBRA '81.²⁶² In TEFRA, Congress sought to overrule these interim final rules by setting forth the financial criteria for determining eligibility.²⁶³ HCFA did not modify its interim final rule to incorporate

447.362 (1984). Contracts with Health Maintenance Organizations and Prepaid Health Plans, 47 Fed. Reg. 43,087 (1982) (proposed Sept. 30, 1982). Another interim final rule implemented a cost containment measure eleven months after the NPRM. 42 C.F.R. § 433.38 (1983). Interest on Disputed Claims, 47 Fed. Reg. 29,275 (1982) (proposed July 6, 1982). Similarly, in 1983, HCFA published an interim final rule revising the methodology for calculating error rates on claims for Medicaid's quality control system followed by a final rule six months later. 42 C.F.R. §§ 431.800-431.803 (1983). 42 C.F.R. § 431.800-431.803 (1984). A 1984 final rule revised the previous rules for calculating claim error rates again. 42 C.F.R. § 431.803 (1984). A 1984 final rule implemented a HCFA initiative to end mandated coverage of early and periodic screening, diagnosis and treatment (EPSDT) services for children two months after publication of the NPRM. 42 C.F.R. §§ 441.50-441.62 (1985). 48 Fed. Reg. 38,016-17 (1983) (proposed Aug. 22, 1983).

257. See Appendix A.

258. See *supra* note 253 and accompanying text. See also CHILDREN'S DEFENSE FUND, COMMENTS OF THE CHILDREN'S DEFENSE FUND ON THE MEDICAID RULEMAKING PROCESS FOR THE FEDERAL ADMINISTRATIVE CONFERENCE 3-4 (Aug. 1990) [hereinafter CHILDREN'S DEFENSE FUND COMMENTS].

259. See *supra* notes 256-57 and accompanying text.

260. See, e.g., Interim Final Rule, Public Notice of Changes in Method or Level of Reimbursement Charges, 46 Fed. Reg. 58,677 (codified at 42 C.F.R. pt. 447 (1988)) (proposed Dec. 3, 1981); Interim Final Rule, State Residency for Institutionalized Individuals, 47 Fed. Reg. 27,076 (codified at 42 C.F.R. pts. 435 and 436 (1988)) (proposed June 23, 1982); Interim Final Rule, Reduction in Error Rate Tolerance, Medicaid Quality Control Program, 48 Fed. Reg. 29,450 (codified at 42 C.F.R. pt. 431 (1988)) (proposed at June 24, 1983); Interim Final Rule, Targeting Information for Income and Eligibility Verification Systems, 54 Fed. Reg. 8738 (to be codified at 42 C.F.R. pts. 433 and 435) (proposed Mar. 2, 1989).

261. Interim Final Rule, Eligibility and Coverage Criteria, 46 Fed. Reg. 47,976 (codified at 42 C.F.R. pts. 435, 436, 440 and 441 (1988)) (proposed Sept. 30, 1981).

262. See A WHITE HOUSE REPORT, H.R. DOC. NO. 21, 97TH CONG., 1ST SESS. (1981); BUDGET REFORM PLAN, H.R. DOC. NO. 21, 97TH CONG., 1ST SESS. (1981); FISCAL YEAR 1982 BUDGET REVISIONS—MESSAGE FROM THE PRESIDENT, H.R. DOC. NO. 26, 97TH CONG., 1ST SESS. (1981); OFFICE OF MANAGEMENT AND BUDGET, FISCAL YEAR 1982 BUDGET REVISIONS: ADDITIONAL DETAILS ON BUDGET SAVINGS (1981), also published as H.R. DOC. 41, 97TH CONG., 1ST SESS. (1981).

263. TEFRA '82 § 137(a)(7)-(9), 96 Stat. 324, 376-81 (codified as amended at 42 U.S.C. §§ 1396a(a)(10)).

the TEFRA provisions. In DEFRA '84, Congress imposed a moratorium on the enforcement of the 1981 interim final regulations.²⁶⁴ When HCFA did not modify its interim final regulations despite the moratorium, Congress passed legislation further directing HCFA to correct the inaccurate regulatory policy in 1987 and prohibiting HCFA from imposing any penalties on states for failing to comply with the interim final rule.²⁶⁵ HCFA has yet to amend its interim final rules to address the moratorium and other constraints imposed by Congress to modify rules which Congress believed were contrary to legislative mandate.²⁶⁶

c. *Interpretative and Procedural Rulemaking*

Since 1981, HCFA has also published an avalanche of interpretative and procedural rules in its *State Medicaid Manual* and other sources, to implement legislative changes as well as to make program changes deemed necessary in its own discretion. Specifically, as of February 1990, in the *State Medicaid Manual*, HCFA had issued over 60 transmittals on state administration, 39 on eligibility policy, 44 on coverage of health care services, ten on payment of providers and seven on quality control since the enactment of OBRA '81.²⁶⁷ These transmittals represent only a small portion of the program guidance that HCFA has issued for the Medicaid program during this period.

HCFA has been quite slow in issuing transmittals to implement legislative changes. For example, MCCA '88 established new requirements for deeming of income and resources of persons whose spouses are institutionalized to be effective October 1, 1989. HCFA issued a transmittal outlining complicated requirements to implement these and other MCCA '88 provisions in October 1989.²⁶⁸ This posed a hardship on states, which were required to implement these provisions regardless of whether HCFA had promulgated regulations or other program instructions by October 1989.

2. *Procedural Challenges to Medicaid Rulemaking*

In making interpretative and procedural rules, HCFA faces the perennial problem of whether the rule has legislative effect and should be promulgated according to the notice-and-comment procedures of § 553 of the APA, or whether it is interpretative or procedural and can be issued without following § 553 procedures. Beneficiaries and providers will invariably claim that deficiencies exist in the procedures used in making rules or policy in order to achieve their ultimate objective of thwarting the implementation of a rule or policy they oppose on substantive grounds. Indeed, such procedural challenges are often proxies for profound ideological differences over the subject of the rule or policy. Yet the fundamental purpose of notice-and-comment rulemaking is to pro-

264. DEFRA '84 § 2373(c), 98 Stat. 494, 1112 (codified as amended at 42 U.S.C. § 1396a(a)(10)(A) & (B) (1989)).

265. Medicare and Medicaid Patient Program Protection Act of 1987 § 9, Pub. L. No. 100-93, 100 Stat. 680, 695-96 amending DEFRA § 2373(c), 98 Stat. 112.

266. See CHILDREN'S DEFENSE FUND COMMENTS, *supra* note 258.

267. HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL Parts 2-7 (1988).

268. HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL, TRANSMITTAL No. 39 (Oct. 1989).

vide a process where political and ideological differences about a proposed rule or policy can surface and hopefully be resolved or at least accommodated.

No other area exemplifies this problem with rule and policy making for the Medicaid program since 1981 better than nursing home reform and the litigation it spawned. This litigation also exemplifies the difficult problem posed for HCFA, as well as states, in implementing congressionally mandated changes under tight deadlines and with limited resources.

In 1982, as discussed above, HCFA issued a controversial NPRM proposing to reduce direct government involvement in monitoring compliance with conditions of participation for nursing homes and thereby deregulate the nursing home industry substantially.²⁶⁹ As noted above, this NPRM generated great opposition among advocates for beneficiaries and Democrats in Congress.²⁷⁰ Indeed, Congress imposed a legislative moratorium on nursing home deregulation in 1982.²⁷¹ In 1987, after the Institute of Medicine's comprehensive study of federal regulation of nursing homes,²⁷² HCFA issued another NPRM prescribing conditions of participation incorporating many of the Institute of Medicine's recommendations.²⁷³ Two months later, Congress enacted OBRA '87 with its comprehensive nursing home reforms again following most of the Institute of Medicine's recommendations.²⁷⁴ HCFA did not publish another NPRM reflecting OBRA '87 changes. On February 2, 1989, HCFA promulgated final rules on conditions of participation which incorporated most of the comprehensive nursing home reform provisions of OBRA '87 and the Institute of Medicine recommendations.²⁷⁵

In *Gray Panthers Advocacy Committee v. Sullivan*,²⁷⁶ nursing home residents and their advocates sought to enjoin implementation of the new conditions of participation on grounds that HCFA published the final regulations implementing OBRA '87 requirements without complying with the notice-and-comment requirements of § 553 of the APA.²⁷⁷ Plaintiffs alleged further that HCFA failed to incorporate some of the mandated changes of OBRA '87 in the conditions of participation for nursing homes.²⁷⁸ The United States District Court for the District of Columbia ruled that no explicit statutory provisions of OBRA '87 required that HCFA promulgate legislative rules designed to implement OBRA '87 nursing home reform and that HCFA did not have to use notice-and-comment rulemaking with respect to new provisions in the rule that

269. Survey and Certification of Health Care Facilities, 47 Fed. Reg. 23,404 (1982) (codified at 42 C.F.R. §§ 490.1-490.60, 405.1901-405.1913, 431.610, 441.15, 442.1-442.112 (1983)) (proposed May 27, 1982). See *supra* note 215 and accompanying text.

270. See *supra* note 215 and accompanying text.

271. See *supra* text accompanying note 160.

272. INST. OF MED., *supra* note 214.

273. Conditions of Participation for Long Term Care Facilities, 52 Fed. Reg. 38,582-01 (1985) (to be codified at 42 C.F.R. pts. 405, 442, and 483) (proposed Oct. 16, 1987).

274. See *supra* note 151 and accompanying text.

275. Conditions of Participation for Long Term Care Facilities, 54 Fed. Reg. 5316 (Feb. 2, 1989), 42 C.F.R. pts. 405, 442, 447, 488, 489 and 498 (1989).

276. No. 89-0605 (D.D.C. June 28, 1989) (LEXIS, Genfed library, Dist. file), [1989-2 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 37,947 (D.D.C. June 28, 1989).

277. See *supra* note 48 and accompanying text.

278. [1989-2 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 37,947 at 20,434.

restated verbatim language of OBRA '87. The court stated: "[W]here the final rule simply restates the specific statutory language, the interests of nursing home residents are protected by virtue of the legislative process in Congress."²⁷⁹ This case is important in its conclusion that, where Congress has not required implementing regulations and has been quite detailed in its statutory prescriptions, courts will probably not conclude that HCFA should have followed § 553 notice-and-comment rulemaking procedures in promulgating rules pertaining to such statutory provisions.

A far more controversial issue has been the survey process for determining nursing home compliance with the conditions of participation. HCFA conducted two rulemaking proceedings in the 1980s regarding the form and methodology used in conducting the survey of nursing homes.²⁸⁰

In *Estate of Smith v. O'Halloran*,²⁸¹ Medicaid nursing home residents in Colorado brought a class action challenging HCFA's failure to make a legislative rule that specified how the survey and certification procedures for nursing homes would assure high quality care for nursing home residents on Medicaid. In 1984, the Tenth Circuit Court of Appeals, reversing the district court, ruled that the Secretary of HHS had a "duty to promulgate regulations which will enable [the Secretary] to be informed as to whether nursing facilities receiving federal Medicaid funds are actually providing high quality medical care."²⁸² Having found that duty, the Tenth Circuit felt bound to "determine whether the enforcement mechanism promulgated by the Secretary satisfie[d] that duty."²⁸³ The court concluded that the existing enforcement mechanism, focusing on characteristics of the facility only and not on the direct care and treatment of the patients, did not comport with the Secretary's duty.²⁸⁴

In 1985, HCFA initiated rulemaking with an NPRM that generally described the survey form and methodology used in the survey and certification of nursing homes²⁸⁵ and promulgated the final rule in June 1986.²⁸⁶ The preamble to the final rule described, generally, the new "Patient Care Services" (PaCS) System for the survey and certification process. The PaCS System, developed by HCFA, required surveyors to interview a representative sample of a nursing home's residents, evaluate their physical condition according to prescribed criteria, examine the residents' medical records, and observe dining, eating assis-

279. *Id.*

280. Long-Term Care Survey, 50 Fed. Reg. 45,584 (1985) (to be codified at 42 C.F.R. pts. 405 and 442) (proposed Oct. 31, 1985); Long-Term Care Survey, 51 Fed. Reg. 21,550 (1986) (codified at 42 C.F.R. pts. 405 and 442 (1988)); Long-Term Care Survey, 52 Fed. Reg. 24,752 (1987) (to be codified at 42 C.F.R. pts. 405, 442 and 488) (proposed July 1, 1987); Long-Term Care Survey, 53 Fed. Reg. 22,850 (1988) (codified at 42 C.F.R. pts. 405, 442 and 448 (1988)).

281. 557 F. Supp. 289 (D. Colo. 1983), *rev'd and rem'd sub. nom.* Estate of Smith v. Heckler, 747 F.2d 583 (10th Cir. 1984), 656 F. Supp. 1093 (D. Colo. 1987), *memorandum opinion and order*, 675 F. Supp. 586 (D. Colo. 1987), *ordered accordingly*. This case formed the basis of a made-for-TV movie, "When You Remember Me." See TV GUIDE, Oct. 7 (1990).

282. Estate of Smith v. Heckler, 747 F.2d 583, 591 (10th Cir. 1984).

283. *Id.*

284. *Id.* at 589-90.

285. Long-Term Care Survey, 50 Fed. Reg. 45,584 (1985) (to be codified at 42 C.F.R. pts. 405 and 442) (proposed Oct. 31, 1985).

286. Long-Time Care Survey, 51 Fed. Reg. 21,550 (June 13, 1986); 42 C.F.R. §§ 405 & 442.30 (1988).

tance and drug administration. There were only two significant changes in the language of the former rule regarding survey procedures: The nursing home's provider agreement with HCFA was no longer definitive evidence that the facility met federal requirements, and the surveying agency was required to use federal "forms, methods and procedures" for the PaCS survey.²⁸⁷

On remand, the district court in *Estate of Smith* invalidated these new rules on several procedural and substantive grounds. First, HCFA's failure to extend the sixty day comment period was arbitrary and capricious because of the controversy over the NPRM and the request of many interested parties pending publication of the Institute of Medicine's study on the regulation of nursing homes.²⁸⁸ The court was also concerned that the PaCS survey text as well as the accompanying methodology and forms were not included in either the NPRM or the final rule. The court concluded that the legislative rule mandated by the Tenth Circuit should have specifically included the PaCS survey form and explicitly addressed the methodologies and procedures for administering the PaCS system. Ordering the Secretary to issue a new NPRM by June 1, 1987, the court stated:

The refusal of the Secretary to be bound by specific procedures, guidelines and forms is a dereliction of his duty as defined in this litigation. The essence of the ruling of the Court of Appeals is that the United States Congress has directed the Secretary to require the facilities to provide such care to Medicaid patients as the Secretary directs through the inspection of care program and the survey certification program. There is no legislative definition of 'quality health care,' and there can be none. It is something which emanates from the process of regulation. The methodology prescribed is the vehicle by which the Secretary will become 'informed as to whether the nursing facilities are actually providing high quality medical care.' *Estate of Smith v. Heckler*, 747 F.2d at 591. Thus, the method is the medium both for defining the expected level of care and for determining performance.²⁸⁹

On July 1, 1987, HCFA published a revised NPRM setting forth a brief rule which referenced five appendices.²⁹⁰ The appendices, also published in the *Federal Register*, included PaCS survey forms on which findings of surveyors could be reported, work sheets, procedural guidelines on the methodologies for conducting the survey and a "resource book" to be used by surveyors in making "informed professional judgments" on facility compliance.²⁹¹ When plaintiffs' in *Smith* challenged this NPRM, HCFA argued that the proposed survey forms, guidelines and other material contained in the appendices were interpretative and procedural rules and, thus, only had to be published for meaningful comment and not for inclusion in the text of the final legislative rule.²⁹² HCFA argued further that including the specific procedures, guidelines and forms in a

287. *Id.* at § 442.30(a)(4).

288. *Estate of Smith*, 656 F. Supp. at 1099. See also INST. OF MED., *supra* note 214.

289. *Estate of Smith*, 656 F. Supp. at 1096-97.

290. Long-Term Care Survey, 52 Fed. Reg. 24,752 (1987) (to be codified at 42 C.F.R. pts. 405 and 442) (proposed July 1, 1987).

291. See *id.* at 24,761-88.

292. *Estate of Smith*, 675 F. Supp. at 588.

legislative rule was undesirable since their subsequent modification and improvements would be slow and difficult.²⁹³

The court rejected HCFA's arguments and found HCFA in "technical" contempt of court for failing to comply with the court's previous opinion.²⁹⁴ The court concluded that the Secretary had to establish "uniform standards for facility performance and a uniform methodology for evaluating that performance to ensure the delivery of high quality health care" and that the regulations "required for these purposes must be prescriptive and legislative."²⁹⁵ Further, the court emphasized that the PaCS survey forms established "substantive requirements for the state and the provider facilities" and that facilities out of compliance would lose their provider agreement which, the court asserted, "can certainly be considered a property right subject to due process protection."²⁹⁶ In responding to HCFA's arguments that quality health care cannot be legislatively defined and that surveyors exercising their professional judgment will "give meaning to [the] phrase," the court stated its essential objections to new HCFA's rulemaking:

The principles in the rule state that the survey process is the means and federal forms will be used. What is the process and what are the forms? They can be changed at any time for any reason and the Secretary is not bound because the rule does not articulate any methodology. Additionally, the required "elements" of a survey set forth in section 442.30(a)(7) do not give any direction or specify any content for the steps stated. Moreover, the Secretary's benign approach in relying on professional judgment rings hollow when there is no federal requirement of professionals on the survey team.²⁹⁷

This is a troubling decision for an agency faced with the need to issue a large volume of program guidance on highly technical issues in relatively short time frames. Clearly HCFA cannot use notice-and-comment rulemaking for all such guidance, particularly for highly technical questions. In many respects, it would seem that the survey forms used by surveyors might be the kind of procedural and interpretative program guidance that need not be promulgated with notice-and-comment rulemaking. On the other hand, the poor, aged and disabled nursing home residents directly affected by the survey are among the most vulnerable in our society and the record of state and federal regulation of nursing homes to protect these residents has not been good.²⁹⁸ Given this situation, it is not surprising that the district court in *Estate of Smith* took a strict view of what rulemaking procedures were required in this case.

Another example of the problems in Medicaid rule and policy making at the federal level are the requirements in OBRA '87 on "minimum criteria" for states to use in making decisions about admission of individuals with mental

293. *Id.*

294. *Id.* The court pointed out that the contempt was "technical" because "it is not the result of a contumacious attitude or a willful disregard of this court's authority and order."

295. *Id.* at 589.

296. *Id.* It should be pointed out that the Supreme Court has specifically ruled that nursing homes do not have a property interest in the Medicaid program. *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980).

297. *Estate of Smith*, 675 F. Supp. at 590.

298. See generally INST. OF MED., *supra* note 214.

illness or retardation to nursing homes.²⁹⁹ OBRA '87 mandated that states have such preadmission screening programs in place by January 1, 1989, and provided that the failure of the Secretary to establish criteria "shall not relieve any State of its responsibility" to conduct preadmission screening.³⁰⁰ If nursing homes failed to apply HCFA's preadmission screening criteria to potential patients, they were subject to sanctions, e.g., decertification, under the Medicare and Medicaid programs.³⁰¹ In September 1988, less than three months before the effective date, HCFA developed and circulated draft criteria.³⁰² There have been three lawsuits by nursing homes and hospitals, their associations and Medicaid beneficiaries seeking to enjoin implementation of the OBRA '87 preadmission screening criteria because HCFA failed to comply with notice-and-comment rulemaking procedures under § 553 of the APA or state rulemaking requirements.

In *Texas Health Care Association v. Bowen*,³⁰³ a federal district court, in granting plaintiffs' motion for a preliminary injunction, ruled that the preadmission screening criteria were legislative rules that should have been promulgated according to APA notice-and-comment rulemaking procedures because it "appears the Congress' delegation of authority to the Secretary to flesh out the statute probably bestows legislative effect upon the Secretary's criteria."³⁰⁴ The court continued: "It is thus unlikely that Congress intended the Secretary to develop such important criteria outside the requirements of the APA."³⁰⁵

The court also commented on the impact of the congressional mandate that states implement the preadmission screening program irrespective of whether HCFA had published the preadmission screening criteria.³⁰⁶ Specifically, the court noted that Texas had difficulty in complying with its own legal requirements for rulemaking. Further HCFA's publication of multiple drafts of the criteria generated confusion as the state and nursing homes sought to comply with the preadmission screening requirements. In concluding that plaintiffs would suffer irreparable injury without the injunction, the court pointed out that patients in need would be denied services because nursing homes were uncertain whether they would ultimately be paid for care given the confusion over the criteria.³⁰⁷

In *Rayford v. Bowen*,³⁰⁸ another federal district court concluded that substantive rules must be promulgated pursuant to § 553 notice-and-comment rulemaking procedures. The court said: "[T]he paradigm of a substantive rule is one which requires obedience on pain of punishment and the draft criteria fit

299. OBRA '87, 42 U.S.C. § 1396r(f)(8) (1988).

300. OBRA '87, 42 U.S.C. § 1396r(e)(7)(A) (1988).

301. OBRA '87, 42 U.S.C. § 1396r(h) (1988).

302. HEALTH CARE FIN. ADMIN., MINIMUM FEDERAL CRITERIA FOR STATES TO USE IN MAKING PREADMISSION AND ANNUAL REVIEW DETERMINATIONS ABOUT ADMISSION TO CONTINUED RESIDENCE IN NURSING FACILITIES FOR INDIVIDUALS WHO HAVE MENTAL ILLNESS OR MENTAL RETARDATION (Sept. 1988).

303. 710 F. Supp. 1109 (W.D. Tex. 1989).

304. *Id.* at 1113, relying on, *Batterton v. Francis*, 432 U.S. 416 (1977); *Herwig v. Ray*, 455 U.S. 265 (1982).

305. *Texas Health Care Ass'n*, 710 F. Supp. at 1113.

306. *Id.* at 1114.

307. *Id.* at 1115.

308. 715 F. Supp. 1347 (W.D. La. 1989).

this definition like a glove.”³⁰⁹ The court also concluded that the criteria could not be interpretative rules essentially because they were prescribing the regulatory structure through which the statute was implemented. The court reasoned further that the criteria were not “based on language found in the statute” and “if Congress leaves gaps in a statute for an agency to fill, then the rules which plug those holes are not interpretations.”³¹⁰

In addition, HCFA argued that Congress created an exception from APA requirements in the case of the criteria by mandating that states implement the preadmission screening criteria regardless of whether HCFA promulgated implementing regulations. The court asserted that, in OBRA '87, Congress had created “a short-lived exception to the APA” for the time period from January 1, 1989, until HCFA finally promulgated implementing regulations.³¹¹ As the court stated: “In short, OBRA creates an exception to the APA only insofar as is needed to ensure that the screening process is in place by 1 January 1989. To give it any greater effect would frustrate the policy goals of the APA.”³¹² The court ruled that, until HCFA promulgated final regulations, nursing homes could not be penalized through decertification for failure to comply with the preadmission screening criteria.³¹³

The *Rayford* court also commented extensively on the confusion that HCFA's handling of the preadmission screening criteria caused for states, nursing homes and Medicaid beneficiaries. The court pointed out that HCFA had published five drafts of the criteria between the filing of the lawsuit and the court's decision.³¹⁴ The court also showed that, to avoid Federal penalties, Louisiana had published a rule providing that the state and providers would comply with HCFA's draft criteria under a Louisiana statute that permits the state to promulgate rules without notice.³¹⁵

However, in *Idaho Health Care Association v. Sullivan*,³¹⁶ the federal district court for Idaho ruled that HCFA's preadmission screening criteria were not legislative rules. The court was persuaded by the fact that Congress had specifically mandated that HCFA develop “criteria” rather than “rules”³¹⁷ and further that HCFA developed “regulations” elsewhere in the statute.³¹⁸ The court also noted that HCFA had agreed not to take punitive action, i.e., decertification, against nursing homes that were out of compliance with the guidelines.³¹⁹

The cases concerning the preadmission screening criteria and nursing home reform have been generally troubling because they demonstrate that, unless HCFA uses notice-and-comment rulemaking, it is exposed to successful proce-

309. *Id.* at 1353.

310. *Id.*, relying on *Brown Express, Inc. v. U.S.*, 607 F.2d 695 (5th Cir. 1979).

311. *Id.* at 1353.

312. *Id.* at 1354.

313. *Id.* at 1353-55.

314. *Id.* at 1349.

315. *Id.*

316. 716 F. Supp. 464 (D. Idaho 1989).

317. *Rayford*, 715 F. Supp. at 1352-53.

318. *Idaho Health Care Ass'n*, 716 F. Supp. at 470.

319. *Id.*

dural challenges from opponents of the rule even where the rules involved are highly technical and detailed. The question of what distinguishes a "legislative" rule from the other rules, for which § 553 notice-and-comment rulemaking procedures are not required, has troubled agencies, courts, and commentators since the enactment of the APA in 1946.³²⁰ The basic problem is that agency rules and policies designated as interpretative or procedural rules often require a regulated party to modify behavior, as would a statute or legislative rule. On the other hand, legislative rules also explain and clarify statutes, establish procedures and otherwise set agency policy. Furthermore, as the United States Court of Appeals for the District of Columbia aptly observed, distinguishing between a legislative or interpretive rule is "an extraordinarily case-specific endeavor."³²¹

In recent years, several court decisions have done much to mitigate agencies' exposure to successful procedural challenges when they promulgate interpretative or procedural rules rather than legislative rules using APA notice-and-comment rulemaking procedures. This developing law on rulemaking, along with case law pertaining specifically to Medicaid program rules (discussed below) should provide some measure of comfort to HCFA in its rule and policy making activities.

Regarding interpretative rules and statements of policy, the Supreme Court's decision in *Chevron U.S.A. v. Natural Resources Defense Council*³²² is important. In this case, the Supreme Court outlined the analytic framework for judicial review of agency interpretations of statutes. Specifically, a reviewing court must give effect to congressional intent where a statute speaks directly to the precise question at issue, but, where a statute is unclear, a reviewing court must accept the agency's interpretation if it is reasonable and "based on a permissible construction of the statute."³²³ It should be noted that the Administrative Conference of the United States has recommended that, in developing definitive interpretations of statutes, agencies should use rulemaking, formal adjudication or other procedures authorized by statute.³²⁴

In cases involving Medicaid regulations, the Supreme Court has been especially deferential to HCFA's interpretation of the Medicaid statute. In both

320. See Davis, *Administrative Rules—Interpretative, Legislative and Retroactive*, 57 YALE L.J. 919 (1948); Bonfield, *Some Tentative Thoughts on Public Participation in the Making of Interpretative Rules and General Statements of Policy Under the A.P.A.*, 23 ADMIN. L. REV. 101 (1971); Koch, *Public Procedures for the Promulgation of Interpretative Rules and General Statements of Policy*, 64 GEO. L.J. 1047 (1976); Asimow, *Public Participation in the Adoption of Interpretive Rules and Policy Statements*, 75 MICH. L. REV. 520 (1977) [hereinafter Asimow, *Public Participation*]; Warren, *The Notice Requirement in Administrative Rulemaking: An Analysis of Legislative and Interpretive Rules*, 29 ADMIN. L. REV. 367 (1977); Mayton, *A Concept of a Rule and the "Substantive Impact" Test in Rulemaking*, 33 EMORY L.J. 889 (1984); Asimow, *Nonlegislative Rulemaking and Regulatory Reform*, 1985 DUKE L.J. 381; Saunders, *Interpretative Rules with Legislative Effect: An Analysis and a Proposal for Public Participation*, 1986 DUKE L.J. 346.

321. *American Hosp. Ass'n v. Bowen*, 834 F.2d 1037, 1045 (D.C. Cir. 1987).

322. 467 U.S. 837 (1984).

323. *Id.* at 842-44. See Anthony, *Which Agency Interpretations Should Bind the Courts and the Public?*, 7 YALE J. ON REG. 1 (1990); Anthony, *Which Agency Interpretations Should Get Judicial Deference — A Preliminary Inquiry*, 40 ADMIN. L. REV. 121 (1988).

324. Admin. Conf. of U.S., Recommendation 89-5, *Achieving Judicial Acceptance of Agency Statutory Interpretations*, 1 C.F.R. § 305.89-5 (1989).

*Herweg v. Ray*³²⁵ and *Schweiker v. Gray Panthers*,³²⁶ the Supreme Court upheld challenged Medicaid regulations in part because of an explicit delegation of authority in the Medicaid statute to interpret the statutory provisions in question. The Supreme Court has also recognized on several occasions that, because of the complexity of the Medicaid program, "Congress conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the [Medicaid] Act."³²⁷

In several recent decisions, the United States Court of Appeals for the District of Columbia has addressed the practical difficulty of distinguishing between legislative and interpretative or procedural rules.³²⁸ Other federal courts of appeals, construing program instructions with detailed guidance for agency personnel on how to perform assigned responsibilities in broad statutory mandates, have come to view them as interpretative or procedural rules, or general statements of policies, even though the instructions contain matters not expressly suggested by the statutory language or impose new obligations on the public.³²⁹

Of particular interest is the District of Columbia Circuit's decision in *American Hospital Association v. Bowen*.³³⁰ This case involved Medicare manual directives and contracting procedures governing Peer Review Organizations and their review of the quality of care provided to Medicare beneficiaries in hospitals and other health care institutions. Many of the HCFA rules and policies at issue in this case are similar to Medicaid rules and policies. The District of Columbia Circuit concluded that the Peer Review Organizations' program manual provisions and contracting procedures were either procedural rules or general statements of policy and, thus, exempt from § 553 notice-and-comment rulemaking procedures. The court aptly articulated the development of the law with respect to procedural rules:

Over time, our circuit in applying the § 553 exemption for procedural rules has gradually shifted focus from asking whether a given procedure has a 'substantive impact' on

325. 455 U.S. 265, 274-75 (1982).

326. 453 U.S. 34, 43-44 (1981).

327. *Atkins v. Rivera*, 477 U.S. 154, 162 (1986) (quoting *Gray Panthers v. Schweiker*, 453 U.S. 34, 43 (1982), and *Batterton v. Francis*, 432 U.S. 416 (1977)). In several cases involving rules for entitlement programs under the Social Security Act, several courts have accorded rules legislative effect even though the agency has not used notice-and-comment rulemaking procedures to promulgate the rule. *See, e.g.*, *U.S. v. Morton*, 467 U.S. 822, 834, *reh. denied*, 468 U.S. 1226 (1984); *Heckler v. Campbell*, 461 U.S. 458, 466 (1983); *Batterton v. Francis*, 432 U.S. 416 (1977). *See Saunders, supra* note 320, at 354-56 & n.53.

328. *See, e.g.*, *American Hosp. Ass'n v. Bowen*, 834 F.2d 1037 (D.C. Cir. 1987); *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561 (D.C. Cir. 1984), *cert. denied*, 471 U.S. 1074 (1985); *Arrow Air, Inc. v. Dole*, 784 F.2d 1118 (D.C. Cir. 1986); *Brock v. Cathedral Bluffs Shale Oil Co.*, 796 F.2d 533 (D.C. Cir. 1986); *National Latino Media Coalition v. FCC*, 816 F.2d 785 (D.C. Cir. 1987); *Thomas v. State of N.Y.*, 802 F.2d 1443 (D.C. Cir. 1986), *cert. denied*, 482 U.S. 919 (1987). *See generally* ADMIN. CONFERENCE OF UNITED STATES, GUIDE TO AGENCY RULEMAKING (2d ed. 1990) [hereinafter GUIDE TO AGENCY RULEMAKING].

329. *See, e.g.*, *United States v. Fitch Oil Co.*, 676 F.2d 673 (T.E.C.A. 1982) (involving audit policies); *United States Dep't of Labor v. Kast Metals Corp.*, 744 F.2d 1145 (5th Cir. 1984) (involving the agency's published priorities for investigations); *Southern Cal. Edison Co. v. FERC*, 770 F.2d 779 (9th Cir. 1985) (involving procedures for approving rates); *Mada-Luna v. Fitzpatrick*, 813 F.2d 1006 (9th Cir. 1987) (involving operating instructions of the Immigration and Naturalization Service directed at the parameters of agency decisionmaking). *See* GUIDE TO AGENCY RULEMAKING, *supra* note 328.

330. 834 F.2d 1037 (D.C. Cir. 1987).

parties . . . to inquiring more broadly whether the agency action also encodes a substantive value judgment or puts a stamp of approval or disapproval on a given type of behavior. The gradual move away from looking solely into the substantiality of the impact reflects a candid recognition that even unambiguously procedural measures affect parties to some degree.³³¹

Finally, *Cubanski v. Heckler*³³² is an interesting decision that addressed the requirements of § 553 with respect to the relationship of HCFA and the states in the Medicaid program. In a state plan amendment, California sought to establish a generous income standard for aged and disabled individuals for its medically needy program under a provision of HCFA's *Regional Office Manual* issued during the Carter administration.³³³ In *Cubanski*, a compliance action brought during the Reagan administration, HCFA asserted that California's income standard rendered its Medicaid program out of compliance with Medicaid program requirements. HCFA argued that the manual instruction on which the California standard was based was not a legislative rule with which it had to comply.³³⁴ The Ninth Circuit, however, concluded that the manual provision was legislative and, indeed, had been properly promulgated as a legislative rule under the APA even though conventional notice-and-comment rulemaking procedures with publication in the *Federal Register* had not been observed. Pointing out that APA procedural requirements are to protect the public's interest and not to "shelter the Secretary," the court concluded:

This case does not involve a defectively promulgated regulation challenged by members of the public who claim that they were harmed by losing their right to participate in the administrative rulemaking process. On the contrary, the State and Intervenor emphasize that they had full awareness of the promulgation and existence of ROM [Regional Office Manual] § 2572-D.³³⁵

Because of the volume of rules and policy that HCFA must issue to manage the Medicaid program properly, and also to keep up with the congressionally mandated program changes each year, HCFA must have rulemaking procedures that enable it to issue detailed guidance to states, providers and the public in a timely and expeditious manner. As a practical matter, HCFA must be able to issue much of this guidance without following APA notice-and-comment rulemaking procedures in every instance. HCFA can issue manual provisions almost immediately. However, for legislative rules, HCFA needs to obtain clearance from other offices within HHS, including the approval of the Secretary. The HHS clearance process can, and usually does, take months. Further, it is well known that APA notice-and-comment rulemaking takes several months in the best of circumstances and much longer for controversial rules.³³⁶

331. 834 F.2d at 1047. See GUIDE TO AGENCY RULEMAKING, *supra* note 328.

332. 781 F.2d 1421 (9th Cir. 1986), *vacated as moot sub. nom. Bowen v. Kizer*, 485 U.S. 386 (1988). After the case had been briefed and argued, Congress mandated that HCFA approve the proposed California plan amendment retroactively to the date of its proposal. OBRA '86 § 4106, 101 Stat. 1330-147.

333. HEALTH CARE FIN. ADMIN., REGIONAL OFFICE MANUAL § 2572-D (1983).

334. *Cubanski*, 781 F.2d at 1427.

335. *Id.* at 1428.

336. See Asimow, *Public Participation*, *supra* note 320, at 530 & 576.

In addition, subsequent review by the Office of Management and Budget can further delay promulgation of final rules.³³⁷

In those cases in which Congress has clearly indicated that some program changes are so necessary that they need immediate implementation, whether or not HCFA promulgates implementing regulations, it makes sense for Congress to identify these particular program changes and address the problems that HCFA faces in meeting APA procedural requirements in a short time frame. For these cases, Congress may want to consider waiving procedural requirements under Chapter V of the APA to facilitate a more orderly rule and policy making process. Further, as in the case of OBRA '87 nursing home reform, Congress could specify in greater detail the programmatic changes in the statute so that implementing regulations would not be needed immediately.

Congress has created an exemption from a sixty day notice-and-comment requirement in the Medicare statute for Medicare regulations pertaining to eligibility, scope of benefits, or payment of providers.³³⁸ Such Medicare regulations are exempt where the statute specifically permits a regulation to be issued in interim final form or "otherwise with a shorter period for public comment" or where the statute "establishes a specific deadline for the implementation of a provision and the deadline is less 150 days after the date of enactment."³³⁹ Passed as a technical amendment in OBRA '86, the purpose of this provision was ostensibly to facilitate rulemaking for the Medicare program in the face of a large volume of congressionally mandated changes annually.³⁴⁰ Finally, it should be noted that HCFA has used interim final rules with a comment period for making Medicaid rules.³⁴¹

In any event, Congress should consider giving HCFA, and states, more time to develop the requisite rules and policies for implementing congressionally mandated changes. Even if HCFA need not promulgate regulations, states still have an extensive policymaking process with which they must comply. Furthermore, additional time will ensure that states use procedures for public participation in their rule and policymaking process. This approach would be especially desirable if HCFA does not use notice-and-comment rulemaking procedures. It would also be desirable in view of the fact that the major responsibility for dealing with beneficiaries and providers resides with the states in the Medicaid program.

337. See Bruff, *Presidential Management of Agency Rulemaking*, 57 GEO. WASH. L. REV. 533 (1989).

338. 42 U.S.C. § 1395hh(a) (1988).

339. *Id.* at § 1395hh(b).

340. OBRA '87 § 4035(b), 101 Stat. 1330-78. Further, Congress expressly exempted national coverage policy under the Medicare program from challenges alleging failure to comply with Chapter V of the APA, ostensibly on the ground that the agency's procedures for making these policies involved public input. 42 U.S.C. § 1395ff(b)(3)(B) (1988). See H.R. Rep. No. 1012, 99th Cong., 2d Sess. (1986). It should be emphasized that the Administrative Conference of the United States expressly recommended that Congress consider repealing this exemption from APA procedural requirements for Medicare national coverage policy. Admin. Conf. of United States, Recommendation 87-8, *National Coverage Determinations under the Medicare Program*, 1 C.F.R. § 305.87-8 (1988). See Kinney, *National Coverage Policy Under the Medicare Program: Problems and Proposals for Change*, 32 ST. LOUIS U.L.J. 869 (1988) [hereinafter, Kinney, *National Coverage Policy*].

341. See *supra* notes 260-66 and accompanying text. See also Appendix A.

Nevertheless, the risks of not using notice-and-comment rulemaking remain. Specifically, interpretative and procedural rules are still vulnerable to procedural challenges by rule opponents and subsequent invalidation by reviewing courts. More importantly, affected parties are not accorded a formal opportunity to participate in the rulemaking proceeding. They may be appropriately concerned that policy, particularly of a controversial nature, will be made in a secreted process in which they will have little or no input. This latter possibility poses a potentially serious problem for the Medicaid program in view of the fact that Medicaid beneficiaries are among the most vulnerable and unsophisticated people in American society.

To address these concerns, HCFA should observe the recommendation of the Administrative Conference of the United States regarding publication of interpretative rules and general statements of policy.³⁴² Concluding that it is difficult at best to distinguish between legislative rules and interpretative rules or policy statements, the Administrative Conference adopted a recommendation that agencies publish all interpretative rules and policy statements of general applicability before promulgation and, if not feasible, that they publish such rules and policy statements after adoption to permit public comment irrespective of the requirements of the APA.³⁴³

Negotiated rulemaking might also be used effectively in the Medicaid rule and policymaking process in some instances. The basic concept of negotiated rulemaking is to convene the major interests affected by a proposed rule before the agency issues the proposed rule and to engage interested parties in a negotiation process that develops a consensus on an acceptable rule accommodating all legitimate concerns.³⁴⁴ Under negotiated rulemaking, affected parties do not simply submit comments on a proposed rule but actually negotiate the contents of the draft rule with the agency in a dialogue directed by a mediator. The Administrative Conference has recommended the use of negotiated rulemaking as a means of avoiding protracted litigation that often follows informal rulemaking under § 553 of the APA where parties have not been so intimately involved with the rulemaking process.³⁴⁵ The Administrative Conference has also recommended use of negotiated rulemaking for national coverage determinations in the Medicare program.³⁴⁶

342. Admin. Conf. of United States, Recommendation 76-5, Interpretive Rules of General Applicability and Statements of General Policy, 1 C.F.R. § 305.76-5 (1988). See Asimow, *Public Participation*, *supra* note 320, at 578-84.

343. 1 C.F.R. § 305.76-5 (1988).

344. Breger, *Thoughts on Accountability and the Administrative Process*, 39 ADMIN. L. REV. 399, 413 (1987). See Perritt, *Negotiated Rulemaking Before Federal Agencies: Evaluation of Recommendations by the Administrative Conference of the United States*, 74 GEO. L.J. 1625 (1986); Susskind & McMahon, *The Theory and Practice of Negotiated Rulemaking*, 3 YALE J. ON REG. 133 (1985); Popper, *An Administrative Law Perspective on Consensual Decisionmaking*, 35 ADMIN. L. REV. 255 (1983); Harter, *Negotiating Regulations: A Cure for Malaise*, 71 GEO. L.J. 1 (1982); Note, *Rethinking Regulation: Negotiation as an Alternative to Traditional Rulemaking*, 94 HARV. L. REV. 1871 (1981).

345. Admin. Conf. of United States, Recommendation 82-4, Procedures for Negotiating Proposed Regulations, 1 C.F.R. § 305.82-4 (1987); Admin. Conf. of United States, Recommendation 85-5, Procedures for Negotiating Proposed Regulations, 1 C.F.R. § 305.85-5 (1987). See Harter, *supra* note 344.

346. Admin. Conf. of United States, Recommendation 87-8, National Coverage Determinations Under the Medicare Program, 1 C.F.R. § 305.87-8 (1988). See Kinney, *National Coverage Policy*, *supra* note 340.

Although designed chiefly for legislative rulemaking, the negotiated rulemaking concept has much to offer HCFA for the Medicaid rule and policy making process.³⁴⁷ HCFA could convene states, provider representatives and beneficiary advocates to negotiate the contents of HCFA rules and policies—particularly those of a complex nature that appear to be creating the problems outlined above. HCFA, as the major payer for Medicaid services, should also be an active participant in these negotiations rather than simply a facilitator, as is the customary role of agencies in other negotiated rulemaking proceedings.

3. *Impact of Delayed Medicaid Rule and Policymaking on States*

HCFA's delays in making rules and policies to implement congressionally mandated changes have had a serious impact on states. Even when Congress requires states to implement a statutory change without implementing regulations from HCFA, states still must amend their state plans, obtain approval of the state plan amendment from HCFA and also change their own rules and policies to implement the requisite program change.³⁴⁸ Where Congress has imposed a tight statutory deadline for implementing a change, states, in some cases, are unable to utilize their customary state rulemaking procedures and often invoke emergency rulemaking procedures, which generally truncate opportunities for public participation.

In many cases, HCFA issues implementing rules and policies just before the statutory deadline or even after the deadline has passed. Sometimes, HCFA does not issue rules or policy in any form, leaving the states to implement congressionally mandated changes without any federal guidance at all. Further, HCFA has often not approved state plan amendments designed to implement changes and requested that states provide additional information, thereby tolling the statutory deadline for approving state plan amendments.³⁴⁹ States are then in the awkward position of being unable to comply with a congressional mandate because of HCFA's not having approved a state plan amendment. This situation is complicated by the fact that HCFA may subsequently reject their state plan amendments or promulgate inconsistent rules or policies which require changes in state implementation procedures.

States are also at financial risk if their rules and policies are inconsistent with federal requirements. Specifically, HCFA can bring a disallowance action to recover past federal payments,³⁵⁰ or claims paid on the basis of state policies can be viewed as errors for purposes of calculating the error rate penalty under

347. See Stewart, *Reformation of American Administrative Law*, 88 HARV. L. REV. 1667 (1975) (This author recommends a comparable negotiation for agency policies that are not promulgated as legislative rules). See also Crampton, *The Why, Where and How of Broadened Public Participation in the Administrative Process*, 60 GEO. L.J. 525 (1972); Sinaiko, *Due Process Rights of Participation in Administrative Rulemaking*, 63 CAL. L. REV. 886 (1975); Comment, *Public Participation in Federal Administrative Proceedings*, 120 U. PA. L. REV. 702 (1972).

348. See *supra* notes 55-58 and accompanying text.

349. See *supra* note 56 and accompanying text.

350. See *supra* notes 70-72 and accompanying text.

the Medicaid quality control system.³⁵¹ In any event, HCFA's actions are programmatically disruptive to state programs, requiring additional changes in state programs that are already in flux.

A good example of this problem with Medicaid rule and policymaking is the implementation of legislation requiring state Medicaid programs to accord special treatment in payment rates to hospitals serving a disproportionate number of Medicaid beneficiaries. In OBRA '81, Congress mandated that payment rates meet the special needs of institutions serving a disproportionate share of the poor.³⁵² In COBRA, Congress ordered the Secretary of HHS to report back to Congress on the methodologies states use to address special needs of disproportionate share hospitals.³⁵³ On reviewing this report, Congress found a "startling record of noncompliance" on the part of states and "indifference, if not hostility" on the part of HCFA and states regarding this requirement.³⁵⁴

In OBRA '87, Congress strengthened this requirement and specifically mandated that states develop a plan for paying more to qualified hospitals by July 1, 1988.³⁵⁵ One month before the statutory deadline of May 1988, by which states had to have payment methodologies for disproportionate share hospitals in place, HCFA issued "interim manual" instructions advising states on how to implement the mandated changes.³⁵⁶

Despite this delay in publishing manual instructions, all states had complied with the July 1, 1988, deadline by submitting state plan amendments to conform to the new requirements or seeking an exemption because their current payment systems adequately compensated disproportionate share hospitals for their higher costs.³⁵⁷ However, as of March 10, 1989 — nine months after the statutory deadline for meeting the new legislative requirements — HCFA had approved the plan amendments of only 15 states.³⁵⁸ Nevertheless, by February 1989, all but nine states were making the requisite payment adjustments to disproportionate share hospitals despite the fact that HCFA had not approved the state plan amendments of many states.³⁵⁹ Medicaid directors reported that HCFA's approval of state plan amendments in this case took longer than usual and several recalled that HCFA had indicated that it would promulgate regulations "to clarify some of the more confusing or difficult-to-implement elements of the law."³⁶⁰ On March 19, 1990, HCFA published an NPRM on Payment

351. See *supra* notes 78-80 and accompanying text.

352. OBRA '81 § 2173, 95 Stat. 808-09 (codified at 42 U.S.C. § 1396a(a)(13)(A) (1988)). This particular requirement has been litigated on several occasions. See, e.g., *SSM Healthcare System v. Reagen*, 681 F. Supp. 625 (W.D. Mo. 1988); *Bethany Med. Cent. v. Harder*, 693 F. Supp. 968 (D. Kan. 1988).

353. COBRA § 9433, 100 Stat. 2067 (current version at 42 U.S.C. § 1396a(h) (1988)).

354. H.R. Rep. No. 100-391(I), 100th Cong., 1st Sess., 525 (1987).

355. OBRA '87 § 4112, 101 Stat. 1330-148 to 1330-150 (codified as amended at 42 U.S.C. § 1396a(a)(13)(A) (1988)). See *supra* note 151 and accompanying text.

356. HEALTH CARE FIN. ADMIN., STATE MEDICAID MANUAL §§ 6000.1-5 (Interim Manual Instructions) Transmittal No. IM88-1 (1988) in 3 MEDICARE & MEDICAID GUIDE (CCH) ¶ 14,725 (1990).

357. D. Lipson, *supra* note 150, at 3.

358. *Id.*

359. *Id.* at 20.

360. *Id.* at 29.

Adjustments for Hospitals that serve a disproportionate number of low-income patients.³⁶¹

This is not an isolated incident. For twenty-three statutory enactments since OBRA '87, HCFA has issued only 15 NPRMs and no final rules.³⁶² In eight of these statutory enactments, HCFA issued manual instructions in the same month or after the statutory deadline by which states had to implement the changes.³⁶³ This kind of delay in getting out guidance to states clearly puts states in an awkward position given the kind of sanctions that HCFA can impose on states if they do not conform to federal requirements. It seems quite unfair to permit HCFA to impose sanctions on states if HCFA has not fully advised states of the program requirements with which they must comply. In an environment of short deadlines and limited resources, HCFA should not be permitted to penalize states that do develop policies as to how they will implement congressionally mandated changes by the deadline.

In these instances, negotiated rulemaking convening representatives of states, such as the National Governors Association, the American Association of Public Welfare Attorneys, state Medicaid directors, as well as provider and beneficiary groups, might be quite useful. Specifically, these groups, with HCFA, could develop state plan amendments or manual provisions that could be used on an interim basis to implement a congressionally mandated change in order to permit states to comply with set deadlines without risk of federal penalties as well as proceed with their own rule and policymaking processes. Such a process would ensure input from affected parties in all aspects of the rulemaking process without some of the time delays associated with notice-and-comment rulemaking.

V. CONCLUSIONS AND RECOMMENDATIONS

The Medicaid program has the daunting assignment of paying for the medical care of many poor, including an increasing number of AIDS patients, in an era of escalating health care costs³⁶⁴ and constrained federal and state budgets. Since the inception of the Medicaid program, Congress has sought to address particularly distressing situations with limited statutory amendments that deal with the immediate need at the lowest possible cost. The result is that the Medicaid program and its statutes, rules, and policies have become extremely and unduly complex, making the program difficult to administer for HCFA and the states.³⁶⁵

361. Proposed Rule, Payment Adjustments for Hospitals that Serve a Disproportionate Number of Low Income Patients, 55 Fed. Reg. 10,077 (proposed Mar. 19, 1990).

362. Letter to Congressman Henry A. Waxman, Chairman, Subcommittee on Health and the Environment, House Committee on Energy and Commerce, to Administrator Gail R. Wilensky, Health Care Financing Administration (Sept. 7, 1990).

363. *Id.*

364. Between 1987 and 1988 (the last year of reported data), national expenditures on health care increased 10.4 percent and comprised 11.1 percent of the Gross National Product. Off. of Nat'l Cost Estimates, *supra* note 6, at 1.

365. Courts have acknowledged that the Medicaid statute is virtually incomprehensible. "The Social Security Act is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has

The complexity contributes to the current problems with Medicaid rule and policymaking. Specifically, the exceptions and special situations in eligibility, benefits, coverage and payment are major reasons for the program's complexity. The Medicaid eligibility policies are especially complicated and doubtlessly unintelligible and bewildering for beneficiaries. Evidence that over 60 percent of the applications for Medicaid based on AFDC eligibility were denied in one year in seventeen states because of applicants' failure to comply with application procedures is extremely disturbing.³⁶⁶ This evidence suggests that the Medicaid program's complexity is having a serious impact on potential and current beneficiaries. While it is beyond the mandate of this study to make recommendations suggesting basic changes in the design of the Medicaid program, it is appropriate to suggest that re-examination of Medicaid policy pertaining to eligibility, benefits, and coverage may be in order.

The problems with Medicaid rule and policymaking since 1981 also stem in large part from a political tug of war between Congress and the Executive Branch about the scope and mission of the Medicaid program in terms of eligible groups as well as benefit and payment levels. The Executive Branch has been chiefly concerned with limiting federal financial commitment to the Medicaid program. Hounded by the federal budget deficit and the respective threats and opportunities posed by the Medicaid program budget in the effort to reduce the deficit, the Executive Branch has retained tight control of federal funds for the Medicaid program. This tight control is manifest in the large number of cost containment and quality control regulations HCFA has promulgated since 1981.³⁶⁷ Like congressionally mandated changes, these regulations also impose additional burdens on states as they adjust their own Medicaid programs to comply.

Compared to the Executive Branch, Congress clearly has a more expansive vision of the Medicaid program and is more inclined to exert federal control over policy on eligibility, benefits and their coverage and payment to providers. Further, Congress has been profoundly concerned about some of the distressing needs of poor infants, children and mothers in this country who suffered cut-backs in Medicaid eligibility and benefits during the early 1980s as well as the plight of the elderly and disabled poor in need of devastatingly expensive long-term care.³⁶⁸ Since 1981, Congress has addressed these problems as well as inequities and gaps in the Medicaid program by extending eligibility to new groups. Many of these legislative changes have endeavored to simplify policy for Medicaid eligibility, benefits and coverage, as well as to minimize difference in Medicaid program requirements across states.

However, the number and pace of these congressional mandates has clearly strained relations between HCFA and the states. Conceding the merit of the

observed, makes the Act 'almost unintelligible to the uninitiated.' " *Friedman v. Berger*, 547 F.2d 724, 727, n.7 (2d Cir. 1976), *cert. denied*, 430 U.S. 984 (1977).

366. See *supra* note 115 and accompanying text.

367. See Appendix A.

368. See *supra* notes 27-37 and accompanying text. See also *Waxman Champions Expansion of Medicaid*, HOSPITALS, Sept. 20, 1986, at 76.

congressionally mandated changes, they still usually require detailed instructions from HCFA for proper and coherent implementation by states. They also impose additional burdens on states that have the ultimate responsibility to serve Medicaid beneficiaries. States are understandably concerned about the federal management of the Medicaid program since 1981 and the onslaught of federally generated program changes each year. In particular, they are concerned about increased Medicaid expenditures in their state budgets and the fact that federal mandates are not accompanied with adequate federal dollars for implementation.³⁶⁹ A recent editorial in the *Washington Post* aptly described the concern of states about congressionally mandated changes as well as the response of many in our society, including the editors of the *Washington Post*, to these concerns:

The Governors have complained about these mandates, saying not without cause that Congress is unfairly spending the money that they are left to raise and sometimes distorting state priorities in the process. Others say that Congress is wrong to peck at the problem of the uninsured, and should await some comprehensive approach to the nation's health care problems. We ourselves have complained about the patchiness of the health legislative process in the past.

But in this case, in merely expanding an established program into an area of need that most people think not only that it already does serve but that it should serve, Congress is right to put the pressure on the states and go ahead. Twenty percent of American children are poor, fewer than half of these are covered by Medicaid, and for them the intellectual and programmatic elegance of a comprehensive approach to health care will be a lifetime too late.³⁷⁰

HCFA is caught in the middle of this tug of war. It has responsibility for dealing with congressionally mandated changes accompanied by short deadlines and sharp political disagreement over how these changes should be implemented. In general, HCFA has dealt with this situation admirably, endeavoring to serve the presidential administration while attempting to meet congressional demands. However, in many instances, HCFA and the Executive Branch have not been expeditious in implementing the legislative will through notice-and-comment rulemaking and other rule and policymaking procedures. These delays and the perceived obstruction of the Executive Branch have motivated Congress to adopt legislative measures to ensure that HCFA and the Executive Branch do not thwart implementation of the law, and in many cases, to correct HCFA interpretations of prior legislative mandates that are contrary to congressional intent.

Below are offered recommendations for procedural changes in the Medicaid program.³⁷¹ These recommendations are targeted chiefly to problems within the domain of administrative law and focus primarily on the promulgation and implementation of rules and policy for the Medicaid program in response to mandated program changes at the federal level.

369. Women, Children and Medicaid, Wash. Post, Dec. 6, 1989, at A28; Hinds, The Governors Talk About Taxing and Spending, N.Y. Times, Oct. 28, 1990, at E5.

370. Women, Children and Medicaid, Wash. Post, Dec. 6, 1989, at A28.

371. The recommendations were developed by the Committee on Rulemaking of the Administrative Conference of the United States on November 8, 1990.

A. *Recommendations to HCFA*

1. When Congress makes any changes to the Medicaid program, and in particular when it expands benefits, HCFA should act promptly to issue rules and policies implementing such changes. Insofar as resource constraints necessitate making choices about the priority in issuing rules and policies, priority should be given to program changes which Congress has identified for prompt implementation or where agency guidance is particularly necessary for their implementation.

2. Where HCFA finds it necessary to promulgate an interim final rule to implement Medicaid program changes, HCFA should permit a subsequent comment period and should avoid delays in publishing its response to the comments and any modification of the rule.³⁷²

3. HCFA should ensure that all rules and policies affecting the administration of the Medicaid program — whether promulgated pursuant to § 553 of the APA or issued in the form of manuals, program memoranda, or letters to states — are readily available to the public at convenient locations.³⁷³ HCFA should also quarterly publish an updated list of such materials in the Federal Register.³⁷⁴

4. a) When Congress requires states to implement Medicaid program changes, HCFA should not penalize states in a disallowance action or impose an error rate penalty if the state has incurred greater Medicaid expenditures than a subsequently issued HCFA rule or policy would otherwise allow. This recommendation applies only where Congress mandates that states change their Medicaid programs with or without HCFA guidance, and where, in the absence of such guidance, a state has submitted a state plan amendment reflecting a reasonable interpretation of the statute to implement the change.

b) Where HCFA issues a final rule or provides other guidance resulting in a program change, it should provide a reasonable grace period (in which penalties are not imposed for noncompliance) to enable states to comply with the new HCFA requirements. This recommendation does not apply where the regulation or guidance, in essence, only tracks the statutory language. As a general matter, HCFA should avoid retroactive program changes.

B. *Recommendations to Congress*

1. Congress should reexamine the Medicaid program's daunting complexity with regard to eligibility, the scope of benefits, and payments to states and providers. This reexamination should seek ways to simplify and clarify these program areas, so far as practicable. Before enacting changes in the Medicaid program, Congress should consult with all parties (particularly HCFA and the

372. The Administrative Conference is currently undertaking a study of agency use of interim final rules.

373. HCFA should devote greater attention to implementing its own salutary regulation in this regard, 42 C.F.R. 431.18.

374. See Admin. Conf. of United States Recommendation 87-8, National Coverage Determinations Under the Medicare Program, 1 C.F.R. § 305.87-8 (1987), and 89-1, Peer Review and Sanctions in the Medicare Program, 1 C.F.R. § 305.89-1 (1989).

states) knowledgeable about the complexities of implementing proposed program changes. Congress should avoid reliance on last-minute budget reconciliation negotiations to make major Medicaid program changes without having first obtained a clear understanding of how HCFA and the states can implement these changes.

2. Before establishing statutory deadlines for implementing legislative changes in the Medicaid program, Congress should consider whether such deadlines allow HCFA and the states adequate time to promulgate the requisite rules or policies and to take other necessary steps for their proper implementation. Where Congress mandates a complex program change to be implemented at the state level, it should allow states a reasonable period of time to engage in state rulemaking procedures before the change becomes effective.

APPENDIX A

PROPOSED AND FINAL REGULATIONS FOR THE MEDICAID PROGRAM ONLY
PROMULGATED BY THE HEALTH CARE FINANCING ADMINISTRATION
JULY 1981 TO FEBRUARY 1990

FINAL RULES

1. Final Rule, Time Limit for States to File Claims, 46 Fed. Reg. 46,134 (Sept. 17, 1981), 42 C.F.R. pt. 95 (1988)
2. Interim Final Rule with a Comment Period, Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964 (Sept. 30, 1981), 42 C.F.R. pt. 447 (1988)
3. Interim Final Rule with a Comment Period, Medicaid Eligibility and Coverage Criteria, 46 Fed. Reg. 47,976 (Sept. 30, 1981), 42 C.F.R. pts. 435, 436, 440 and 441 (1988)
4. Interim Final Rule, Reductions in Payments to the States, 46 Fed. Reg. 47,996 (Sept. 30, 1981), 42 C.F.R. pt. 443, 45 C.F.R. pt. 201 (1988)
5. Notice of Proposed Rulemaking, Offset Based on Third Party Liability Recoveries Against Reductions in Medicaid Payments, 46 Fed. Reg. 48,006 (Sept. 30, 1981), 42 C.F.R. pt. 433 (1988)
6. Interim Final Rule with a Comment Period, Freedom of Choice: Waivers of and Exceptions to State Plan Requirements, 46 Fed. Reg. 48,524 (Oct. 1, 1981), 42 C.F.R. pts. 431 and 440 (1988)
7. Interim Final Rule with a Comment Period, Home and Community-Based Services, 46 Fed. Reg. 48,532 (Oct. 1, 1981), 42 C.F.R. pts. 431, 435, 440 and 441 (1988)
8. Interim Final Rule with a Comment Period, Miscellaneous Medicaid Provisions—Increased State Flexibility, 46 Fed. Reg. 48,556 (Oct. 1, 1981), 42 C.F.R. pts. 430, 433, 435, 441, 447 and 456 (1988)
9. Interim Final Rule with a Comment Period, Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964 (Sept. 30, 1981), 42 C.F.R. pt. 447 (1988)
10. Interim Final Rule with a Comment Period, Public Notice of Changes in Method or Level of Reimbursement, 46 Fed. Reg. 58,677 (Dec. 3, 1981), corrected at 47 Fed. Reg. 8567 (Mar. 1, 1982), 42 C.F.R. pt. 477 (1988)
11. Interim Final Rule with a Comment Period, State Residency for Institutionalized Individuals, 47 Fed. Reg. 27,076 (June 23, 1982), 42 C.F.R. pts. 435 and 436 (1988)
12. Final Rule, Entitlement of Children for Whom Payments Are Made Under the Foster Care Maintenance Payments Program or the Adoption Assistance Program, 47 Fed. Reg. 28,652 (July 1, 1982), 42 C.F.R. pts. 431, 435 and 436 (1988)

13. Final Rule Correction, Miscellaneous Corrections, 47 Fed. Reg. 30,764 (July 15, 1982), 42 C.F.R. pt. 435 (1988)
14. Correction of Interim Final Rule, Nurse-Midwife Services, Correction, 47 Fed. Reg. 31,878 (July 23, 1982), 42 C.F.R. pt. 441 (1988)
15. Final Rule, Requirements Applicable to Sterilizations (Hysterectomies), 47 Fed. Reg. 33,695 (Aug. 4, 1982), 42 C.F.R. pts. 50 and 441, 45 C.F.R. pt. 96 (1988)
16. Final Rule, Expanded Phase-Out Provisions of Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Correction Plans, 47 Fed. Reg. 37,547 (Aug. 26, 1982), 42 C.F.R. pt. 442 (1988)
17. Final Rule, Reductions in Payments to the States, 47 Fed. Reg. 43,340 (Sept. 30, 1982), 42 C.F.R. pt. 433 (1988)
18. Final Rule with a Comment Period, Liens, Adjustments, and Recoveries, 47 Fed. Reg. 43,644 (Oct. 1, 1982), 42 C.F.R. pts. 443, 435 and 436 (1988)
19. Final Rule with a Comment Period, Imposition of Cost Sharing Charges under Medicaid, 48 Fed. Reg. 5730 (Feb. 8, 1983), 42 C.F.R. pts. 431, 435, 436, 440 and 447 (1988)
20. Final Rule, Freedom of Choice; Waivers of and Exceptions to State Plan Requirements, 48 Fed. Reg. 23,212 (May 24, 1983), 42 C.F.R. pt. 431 (1988)
21. Interim Final Rule with a Comment Period, Reduction in Error Rate Tolerance, Medicaid Quality Control Program, 48 Fed. Reg. 29,450 (June 24, 1983), 42 C.F.R. pt. 431 (1988)
22. Final Rule, Interest on Disputed Medicaid Claims, 48 Fed. Reg. 29,480 (June 27, 1983), 42 C.F.R. pt. 433 (1988)
23. Final Rule with a Comment Period, Deeming of Income Between Spouses; Categorically Needy, 48 Fed. Reg. 39,624 (Sept. 1, 1983), 42 C.F.R. pts. 435 and 436 (1988)
24. Final Rule, State Medicaid Contracts, 48 Fed. Reg. 54,013 (Nov. 30, 1983), corrected at 48 Fed. Reg. 55,128 (Dec. 9, 1983), 42 C.F.R. pts. 431, 434, 435 and 447 (1988)
25. Final Rule, Reduction in Error Rate Tolerance; Medicaid Quality Control Program, 48 Fed. Reg. 54,224 (Dec. 1, 1983), 42 C.F.R. pt. 431 (1988)
26. Final Rule, Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 48 Fed. Reg. 56,046 (Dec. 19, 1983), 42 C.F.R. pt. 447 (1988)
27. Final Rule, Reduction in Error Rate Tolerance; Medicaid Quality Control Program, 49 Fed. Reg. 4740 (Feb. 8, 1984), 42 C.F.R. pt. 431 (1988)
28. Final Rule, State Residency Requirements, 49 Fed. Reg. 13,526 (Apr. 5, 1984), 42 C.F.R. pts. 435 and 436 (1988)

29. Final Rule Notice Concerning Collection of Information Requirements, OMB Approval of Forms for Reporting Quarterly Expenditures for Medical Assistance, 49 Fed. Reg. 29,795 (July 24, 1984), 42 C.F.R. pt. 433 (1988)
30. Final Rule, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, 49 Fed. Reg. 43,654 (Oct. 31, 1984), corrected at 49 Fed. Reg. 45,431 (Nov. 16, 1984), 42 C.F.R. pts. 400 and 441 (1988)
31. Correction of Final Rule, Home and Community-Based Services, 50 Fed. Reg. 10,013 (Mar. 13, 1985), corrected at 50 Fed. Reg. 25,079 (June 17, 1985), 42 C.F.R. pts. 435, 436, 440 and 441 (1988)
32. Correction of Final Rule, Federal Financial Participation for Inmates in Public Institutions and Individuals in an Institution for Mental Disease or Tuberculosis, 50 Fed. Reg. 13,196 (Apr. 3, 1985), corrected at 50 Fed. Reg. 38,811 (Sept. 25, 1985), 42 C.F.R. pts. 435-436 (1988)
33. Final Rule, Claims Processing Assessment Systems (CPAS), 50 Fed. Reg. 21,839 (May 29, 1985), 42 C.F.R. pt. 431 (1988)
34. Final Rule, Imposition of Cost Sharing Charges under Medicaid, 50 Fed. Reg. 23,009 (May 30, 1985), 42 C.F.R. pts. 431 and 447 (1988)
35. Final Rule, Medicaid Management Information Systems; Conditions of Approval and Reapproval and Procedures for Reduction of Federal Financial Participation, 50 Fed. Reg. 30,838 (July 30, 1985), 42 C.F.R. pts. 400 and 433 (1988)
36. Final Regulations, Third-Party Liability For Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation, 50 Fed. Reg. 46,652 (Nov. 12, 1985), 42 C.F.R. pts. 432, 433, 435 and 436 (1988)
37. Final Rule, Eligibility to Severely Impaired Individuals Who Perform Substantial Gainful Activity, 50 Fed. Reg. 46,760 (Nov. 13, 1985), 20 C.F.R. pt. 416; 42 C.F.R. pt. 435 (1988)
38. Final Rule with a Comment Period, Treatment of Social Security Cost-of-Living Increase for Individuals Who Lose SSI Eligibility, 51 Fed. Reg. 12,325 (Apr. 10, 1986), 42 C.F.R. pt. 435 (1988)
39. Final Rule, Fire-Safety Standards for ICFs/MR, 51 Fed. Reg. 13,224 (Apr. 18, 1986), 42 C.F.R. pt. 442 (1988)
40. Final Rule, Third-Party Liability for Medical Assistance, Corrected at 51 Fed. Reg. 16,318 (May 2, 1986), 42 C.F.R. pt. 433 (1988)
41. Final Rule, Mental Retardation; Definition of "Persons with Related Conditions," 51 Fed. Reg. 19,177 (May 28, 1986), 42 C.F.R. pt. 435 (1988)
42. Final Rule, Adjustment of Federal Share for Uncashed or Cancelled (Voided) Checks, 51 Fed. Reg. 36,225 (Oct. 9, 1986), 42 C.F.R. pts. 430 and 433; 45 C.F.R. pt. 201 (1988)

43. Final Rule, Automatic Data Processing Equipment and Services; Conditions for Federal Financial Participation, 51 Fed. Reg. 45,321 (Dec. 18, 1986), 45 C.F.R. pts. 95, 205 and 307; 42 C.F.R. pt. 433 (1988)
44. Final Rule, Identification of Third-Party Liability Resources for Medical Assistance, 52 Fed. Reg. 5967 (Feb. 27, 1987), 42 C.F.R. pts. 431, 433 and 435 (1988)
45. Final Rule with a Comment Period, Revisions to Medicaid Payments for Hospital and Long-Term Care Facility Services, 52 Fed. Reg. 28,141 (July 28, 1987), 42 C.F.R. pts. 400 and 447 (1988)
46. Final Rule, Federal Financial Participation for Services of Long-Term Care Facilities, 52 Fed. Reg. 32,544 (Aug. 28, 1987), 42 C.F.R. pts. 441 and 442 (1988)
47. Final Rule, Coverage of Qualified Pregnant Women and Children and Newborn Children, 52 Fed. Reg. 43,063 (Nov. 9, 1987), 42 C.F.R. pts. 435 and 436 (1988)
48. Final Rule, Relations with Other Agencies, Miscellaneous Medicaid Definitions, Third-Party Liability Quality Control, and Limitations on Federal Funds for Abortions, 52 Fed. Reg. 47,926 (Dec. 17, 1987), 42 C.F.R. pts. 431, 435, 440 and 441 (1988)
49. Final Rule, Withholding of Payments for Fraud or Willful Misrepresentation, 52 Fed. Reg. 48,814 (Dec. 28, 1987), 42 C.F.R. pt. 455 (1988)
50. Final Rule, Automatic Data Processing Equipment and Services, Conditions of Federal Financial Participation, 53 Fed. Reg. 26 (Jan. 4, 1988), 45 C.F.R. pt. 95 (1988)
51. Final Rule, End State Renal Disease Program, Responsibilities for Network Organizations, 53 Fed. Reg. 1617 (Jan. 21, 1988), 42 C.F.R. pt. 405 (1988)
52. Final Rule, Corrections and Reduction Plans for Intermediate Care Facilities for the Mentally Retarded, 53 Fed. Reg. 1984 (Jan. 25, 1988), 42 C.F.R. pt. 442 (1988)
53. Final Rule, Medicaid Program Payments to Institutions, 53 Fed. Reg. 3586 (Feb. 8, 1988), corrected at 53 Fed. Reg. 5344 (Feb. 23, 1988), 42 C.F.R. pt. 435 (1988)
54. Final Rule, Conditions for Intermediate Care Facilities for the Mentally Retarded, 53 Fed. Reg. 20,448 (June 3, 1988), 42 C.F.R. pts. 431, 435, 440, 442 and 483 (1988)
55. Final Rule, Appeals For Cancellation of Approval of Medicaid Long-Term Care Facilities, 53 Fed. Reg. 31,334 (Aug. 18, 1988), 42 C.F.R. pt. 498 (1988)

56. Final Rule with a Comment Period, Requirements State Plans and Grants for States, 53 Fed. Reg. 36,569 (Sept. 21, 1988), 42 C.F.R. pts. 400 and 430; 45 C.F.R. pts. 201, 204, 205, 211, 212, 213, and 282 (1988)
57. Final Rule, Refunding of Federal Share of Overpayments Made to Medicaid Providers, 54 Fed. Reg. 5452 (Feb. 3, 1989) corrected at 54 Fed. Reg. 8435 (Feb. 28, 1989) (to be codified at 42 C.F.R. pt. 433)
58. Interim Final Rule With a Comment Period, Targeting Information for Income and Eligibility Verification Systems, 54 Fed. Reg. 8738 (Mar. 2, 1989) (to be codified at 42 C.F.R. pts. 433 and 435)
59. Final Rule With Technical Correction, Approved Information Collection Requirements and Federal Medical Percentage Computation, 54 Fed. Reg. 21,065 (May 16, 1989) (to be codified at 42 C.F.R. pts. 400 and 433)
60. Final Rule With a Comment Period, Medicaid Management Information System: Revised Definition of "Mechanized Claims Processing and Information Retrieval System," 54 Fed. Reg. 41,966 (Oct. 13, 1989) (to be codified at 42 C.F.R. pt. 433)
61. Final Rule, Eligibility Determinations Based on Disability, 54 Fed. Reg. 50,755 (Dec. 11, 1989) (to be codified at 42 C.F.R. pts. 435 and 436)
62. Final Rule, State Plan Requirements and Other Provisions Relating to State Third Party Liability Programs, 55 Fed. Reg. 1423 (Jan. 16, 1990) (to be codified at 42 C.F.R. pt. 433)
63. Final Rule, Medicaid Disability Determinations, 55 Fed. Reg. 290 (Dec. 11, 1989) (to be codified at 42 C.F.R. pts. 435 and 436)
64. Final Rule, Membership Requirements and State Option for Disenrollment Restrictions for HMOs under Medicaid, 55 Fed. Reg. 23, 738 (June 12, 1990) (to be codified at 42 C.F.R. pts. 434 and 435)

PROPOSED RULES

1. Proposed Rule, Extended Phase Out Provisions of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) Correction Plans, 46 Fed. Reg. 42,698 (Aug. 24, 1981)
2. Proposed Rule, Revocation of Sixty-Day Public Notice of Changes in Method or Level of Reimbursement, 46 Fed. Reg. 45,964 (Sept. 16, 1981)
3. Proposed Rule, Offset Based on Third Party Liability Recoveries Against Reductions in Medicaid Payments, 46 Fed. Reg. 48,006 (Sept. 30, 1981)
4. Proposed Rule, Interest on Disputed Claims, 47 Fed. Reg. 29,275 (July 6, 1982)
5. Proposed Rule, Deeming of Income Between Spouses; Categorically Needy, 47 Fed. Reg. 31,899 (July 23, 1982)

6. Proposed Rule, Contracts with Health Maintenance Organizations and Prepaid Health Plans, 47 Fed. Reg. 43,087 (Sept. 30, 1982)
7. Proposed Rule, State Residency Requirements, 47 Fed. Reg. 43,095 (Sept. 30, 1982)
8. Proposed Rule, Mental Retardation—Definition of “Persons with Related Conditions,” 48 Fed. Reg. 7593 (Feb. 23, 1983)
9. Proposed Rule, Medicaid Management Information Systems: Conditions of Approval and Reapproval and Procedures for Reduction of Federal Financial Participation, 48 Fed. Reg. 9038 (Mar. 3, 1983)
10. Proposed Rule, Relation with Other Agencies and Miscellaneous Medicaid Definitions, 48 Fed. Reg. 10,378 (Mar. 11, 1983)
11. Proposed Rule, Federal Financial Participation for Inmates in Public Institutions and Individuals in an Institution for Mental Disease or Tuberculosis, 48 Fed. Reg. 13,446 (Mar. 31, 1983) •
12. Proposed Rule, Medicaid Overpayment Reporting Requirements, 48 Fed. Reg. 14,664 (Apr. 5, 1983), 42 C.F.R. pt. 442
13. Proposed Rule, Claims Processing Assessment System, 48 Fed. Reg. 36,151 (Aug. 9, 1983), 42 C.F.R. pt. 431
14. Proposed Rule, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, 48 Fed. Reg. 38,011 (Aug. 22, 1983), 42 C.F.R. pt. 441
15. Proposed Rule, Reduction in Eligibility Error Rate Tolerance Beginning October 1, 1983, Medicaid Quality Control Program, 48 Fed. Reg. 39,476 (Aug. 31, 1983), 42 C.F.R. pt. 431
16. Proposed Rule, Deduction of Incurred Medical Expenses (Spend Down), 48 Fed. Reg. 39,959 (Sept. 2, 1983), 42 C.F.R. pts. 435 and 436
17. Proposed Rule, Third-Party Liability for Medical Assistance; FFP Rates for Skilled Professional Medical Personnel and Supporting Staff; and Sources of State Share of Financial Participation, 49 Fed. Reg. 23,078 (June 4, 1984), 42 C.F.R. pts. 432 and 433
18. Proposed Rule, Revisions to Medicaid Payment for Hospital and Long-Term Care Facility Services, 51 Fed. Reg. 5728 (Feb. 18, 1986), 42 C.F.R. pt. 447
19. Proposed Rule, Payments to Institutions, 50 Fed. Reg. 10,992 (Mar. 19, 1985), 42 C.F.R. pts. 435 and 436
20. Proposed Rule, Treatment of Social Security Cost of Living Increases for Individuals Who Lose SSI Eligibility, 50 Fed. Reg. 14,397 (Apr. 12, 1985), 42 C.F.R. pt. 435
21. Proposed Rule, Income and Eligibility Verification, 50 Fed. Reg. 10,481 (Mar. 14, 1985), 42 C.F.R. pts. 431 and 435

22. Proposed Rule, Adjustment for Federal Share of Uncashed or Cancelled (Voided) Checks, 50 Fed. Reg. 23,147 (May 31, 1985), 42 C.F.R. pt. 430 and 45 C.F.R. pt. 201
23. Proposed Rule, Federal Financial Participation for Services of Long-Term Care Facilities, 50 Fed. Reg. 42,192 (Oct. 18, 1985), 42 C.F.R. pt. 442
24. Proposed Rule, Coverage of Qualified Pregnant Women and Children and Newborn Children, 50 Fed. Reg. 48,102 (Nov. 21, 1985), 42 C.F.R. pts. 435 and 436
25. Proposed Rule, Fire Safety Standards for ICFs/MR, 50 Fed. Reg. 45,921 (Nov. 5, 1985), 42 C.F.R. pt. 442
26. Proposed Rule, Revisions to Medicaid Payment for Hospital and Long-Term Care Facility Services, 51 Fed. Reg. 5728 (Feb. 18, 1986), 42 C.F.R. pt. 447
27. Proposed Rule, Standards for Intermediate Care Facilities for the Mentally Retarded, 51 Fed. Reg. 7520 (Mar. 4, 1986), 42 C.F.R. pts. 435 and 442
28. Proposed Rule, Identification of Third-Party Liability Resources for Medical Assistance, 51 Fed. Reg. 19,227 (May 28, 1986), 42 C.F.R. pts. 431 and 433
29. Proposed Rule, Mandatory Second Surgical Opinion Requirements for Medicaid Recipients, 51 Fed. Reg. 21,933 (June 17, 1986), 42 C.F.R. pt. 431
30. Proposed Rule, Correction and Reduction Plans for Intermediate Care Facilities for the Mentally Retarded, 51 Fed. Reg. 26,718 (July 25, 1986), 42 C.F.R. pt. 442
31. Proposed Rule, Revision of Medicaid Eligibility Quality Control (MEQC) Program Requirements, 52 Fed. Reg. 2733 (Jan. 26, 1987), 42 C.F.R. pt. 431
32. Proposed Rule, State Plan Requirements and Other Provisions Relating to State Third-Party Liability Programs, 52 Fed. Reg. 6350 (Mar. 3, 1987), 42 C.F.R. pts. 433 and 447
33. Proposed Rule, Automatic Data Processing Equipment and Services; Conditions for Federal Financial Participation, 52 Fed. Reg. 35,454 (Sept. 21, 1987), 42 C.F.R. pts. 95, 205 and 307
34. Proposed Rule, Eligibility Determinations Based on Disability, 52 Fed. Reg. 47,414 (Dec. 14, 1987), 42 C.F.R. pts. 435 and 436
35. Proposed Rule, Refunding of Federal Share of Overpayments Made to Medicaid Providers, 52 Fed. Reg. 48,290 (Dec. 21, 1987), 42 C.F.R. pt. 433
36. Proposed Rule, Waiver of Certain Membership Requirements for Certain Health Maintenance Organizations (HMOs), and State Option for Disenrollment Restrictions for Certain HMOs Under Medicaid, 53 Fed. Reg. 744 (Jan. 12, 1988), 42 C.F.R. pts. 434 and 435

37. Proposed Rule, Eligibility of Qualified Severely Impaired Individuals Who Work, 53 Fed. Reg. 15,857 (May 4, 1988)
38. Proposed Rule, Home and Community-Based Services and Respiratory Care for Ventilator-Dependent Individuals, 53 Fed. Reg. 19,950 (June 1, 1988)
39. Proposed Rule, Coverage of Personal Care Services, 53 Fed. Reg. 24,103 (June 27, 1988)
40. Proposed Rule, Medicaid Management Information System: Revised Definition of "Mechanized Claims Processing and Information Retrieval System," 53 Fed. Reg. 30,317 (Aug. 11, 1988), corrected at 53 Fed. Reg. 31,801 (Aug. 19, 1988)
41. Proposed Rule, What Is Not Income Under SSI, 53 Fed. Reg. 32,252 (Aug. 24, 1988)
42. Proposed Rule, Modification of Certain Requirements for Health Insuring Organizations, 53 Fed. Reg. 32,406 (Aug. 25, 1988)
43. Proposed Rule, Eligibility of Aliens for Medicaid, 53 Fed. Reg. 38,032 (Sept. 29, 1988)
44. Proposed Rule, Eligibility Groups, Coverage and Conditions of Eligibility, Legislative Changes under OBRA '87, COBRA, and TEFRA, 54 Fed. Reg. 7798 (Feb. 23, 1989)
45. Proposed Rule, Eligibility and Coverage Requirements, 54 Fed. Reg. 39,421 (Sept. 26, 1989)
46. Proposed Rule, Limiting Donations and Taxes as State Medicaid Funding, 55 Fed. Reg. 4626 (Feb. 9, 1990), 42 C.F.R. pt. 433

APPENDIX B

PROPOSED AND FINAL RULES FOR THE MEDICARE AND MEDICAID PROGRAMS
PROMULGATED BY THE HEALTH CARE FINANCING ADMINISTRATION
JULY 1981 TO FEBRUARY 1990

FINAL RULES

1. Final Rule, Reimbursement for Clinical Laboratory Services, 46 Fed. Reg. 42,669 (Aug. 24, 1981), 42 C.F.R. pts. 405, 440 and 447 (1988)
2. Final Rule, Less Than Effective Drugs and Inpatient Hospital Tests, 46 Fed. Reg. 48,550 (Oct. 1, 1981), 42 C.F.R. pts. 405 and 441 (1988)
3. Final Rule, Less Than Effective Drugs, 46 Fed. Reg. 53,664 (Oct. 30, 1981), 42 C.F.R. pts. 405 and 441 (1988)
4. Final Rule, Correction, 46 Fed. Reg. 54,743 (Nov. 4, 1981), 42 C.F.R. pts. 405, 431, 433, 435, 436, 440, 447, 456, 463, 466, and 478 (1988)
5. Final Rule, Less Than Effective Drugs, 47 Fed. Reg. 1386 (Jan. 13, 1982), 42 C.F.R. pts. 405 and 441 (1988)
6. Final Rule, Continuation of Benefits and Eligibility for Certain Severely Impaired Recipients Who Work, 47 Fed. Reg. 15,319 (Apr. 9, 1982), 20 C.F.R. pt. 416 (1988)
7. Final Rule, Less Than Effective Drugs, 47 Fed. Reg. 16,339 (Apr. 16, 1982), 42 C.F.R. pts. 405 and 441 (1988)
8. Final Rule, Nurse-Midwife Services, 47 Fed. Reg. 21,046 (May 17, 1982), 42 C.F.R. pts. 405, 435, 436, 440, 441 and 447 (1988)
9. Final Rule, Rural Hospitals: Provision of Long-Term Care Services (Swing-Bed Provision), Flexibility in Application of Standards, 47 Fed. Reg. 31,518 (July 20, 1982), 42 C.F.R. pts. 405, 435, 440, 442 and 447 (1988)
10. Final Rule, Miscellaneous Amendments, 47 Fed. Reg. 47,388 (Oct. 26, 1982), 42 C.F.R. pts. 405 and 442 (1988)
11. Final Rule, Suspension of Health Care Professionals for Conviction of Program-Related Crimes; Exclusion of Medicaid Providers for Fraud and Abuse, 48 Fed. Reg. 3742 (Jan. 27, 1983), 42 C.F.R. pts. 420, 455 and 489 (1988)
12. Final Rule, Medicare, Medicaid, and Maternal and Child Health Services Block Grant Programs; Civil Money Penalties and Assessments for False or Improper Claims, 48 Fed. Reg. 38,827 (Aug. 26, 1983), 45 C.F.R. pt. 101 (1988)
13. Final Rule, OMB Control Numbers for Collections of Information Contained in HCFA Regulations, 49 Fed. Reg. 4476 (Feb. 7, 1984), 42 C.F.R. pt. 400 (1988)

14. Final Rule, Utilization and Quality Control Peer Review Organization (PRO): Assumption of Medicare Review Functions and Coordination With Medicaid, 50 Fed. Reg. 15,312 (Apr. 17, 1985), 42 C.F.R. pts. 400, 405, 412, 431, 433, 456, 460, 462 and 466 (1988)
15. Final Rule, Withholding the Federal Share of Payments to Recover Medicare or Medicaid Overpayments, 50 Fed. Reg. 19,684 (May 10, 1985), 42 C.F.R. pts. 400, 405 and 447 (1988)
16. Final Rule, OMB Control Numbers for Collections of Information Contained in HCFA Regulations, 50 Fed. Reg. 28,577 (July 15, 1985), 42 C.F.R. pts. 400, 416 and 435 (1988)
17. Final Rule, Corrections and Conforming Changes, 50 Fed. Reg. 33,027 (Aug. 16, 1985), 20 C.F.R. pt. 450, 42 C.F.R. pts. 400, 405, 408, 409, 442, 456, 481, 485, 488 and 491 (1988)
18. Final Rule, OMB Control Numbers for Collection of Information Requirements Contained in HCFA Regulations, 51 Fed. Reg. 9792 (Mar. 21, 1986), 42 C.F.R. pt. 400 (1988)
19. Final Rule, Payment for the Cost of Malpractice Insurance, 51 Fed. Reg. 11,142 (Apr. 11, 1986), 42 C.F.R. pt. 405 (1988)
20. Final Rule, OMB Control Numbers for Collection of Information Requirements Contained in HCFA Regulations, 51 Fed. Reg. 11,581 (Apr. 4, 1986), 42 C.F.R. pt. 400 (1988)
21. Final Rule, Conditions of Participation for Hospitals, 51 Fed. Reg. 22,010 (June 17, 1986), 42 C.F.R. pts. 405, 412, 416, 417, 440, 441, 456, 482 and 489 (1988)
22. Final Rule, Miscellaneous Medicare and Medicaid Amendments, 51 Fed. Reg. 23,541 (June 30, 1986), 42 C.F.R. pts. 405, 409 and 442 (1988)
23. Final Rule, Conditions of Participation for Hospitals; Corrections, 51 Fed. Reg. 27,847 (Aug. 4, 1986), 42 C.F.R. pt. 405 and 482 (1988)
24. Final Rule, Program Integrity, 51 Fed. Reg. 34,786 (Sept. 30, 1986), 42 C.F.R. pts. 412, 420, 455, 466, 474 and 489 (1988)
25. Final Rule, Establishment of Chapter V for OIG Regulations, 51 Fed. Reg. 34,764 (Sept. 30, 1986); 42 C.F.R. Ch. V, 45 C.F.R. pt. 101 (1988)
26. Final Rule, Miscellaneous Conforming Amendments, 51 Fed. Reg. 41,332 (Nov. 14, 1986), 42 C.F.R. pts. 405, 406, 408, 409, 410, 421, 431, 433, 435 and 489 (1988)
27. Final Rule, OMB Control Numbers for Collection of Information Requirements Contained in HCFA Regulations, 51 Fed. Reg. 44,987 (Dec. 16, 1986), 42 C.F.R. pt. 400 (1988)

28. Final Rule, OMB Control Numbers for Collection of Information Requirements Contained in HCFA Regulations, 51 Fed. Reg. 44,986 (Dec. 16, 1986), 42 C.F.R. pt. 400 (1988)
29. Final Rule, OMB Control Numbers for Collection of Information Requirements Contained in HCFA Regulations, 51 Fed. Reg. 44,985 (Dec. 16, 1986), 42 C.F.R. pt. 400 (1988)
30. Final Rule, Payment for the Cost of Malpractice Insurance, 52 Fed. Reg. 9833 (Mar. 27, 1987), 42 C.F.R. pt. 413 (1988)
31. Final Rule, OMB Control Numbers for Collection of Information Requirements Contained in HCFA Regulations, 52 Fed. Reg. 11,647 (Apr. 10, 1987), 42 C.F.R. pts. 400 and 482 (1988)
32. Final Rule, Benefit Period Determinations, Drug Regimen Reviews and Other Technical Changes, 52 Fed. Reg. 22,638 (June 15, 1987), 42 C.F.R. pts. 405, 409 and 442 (1988)
33. Final Rule, Limits on Payments for Drugs, 52 Fed. Reg. 28,648 (July 31, 1987), 42 C.F.R. pts. 413, 430 and 447, 45 C.F.R. pts. 1 and 19 (1988)
34. Final Rule, Redesignation of Rules Concerning Federal Requirements for Health Maintenance Organizations, 52 Fed. Reg. 36,746 (Sept. 30, 1987), 42 C.F.R. pts. 110 and 417 (1988)
35. Final Rule, Entities Performing Quality of Care Review of Services Provided by Risk-Basis Health Maintenance Organizations and Competitive Medical Plans, 52 Fed. Reg. 37,454 (Oct. 7, 1987), 42 C.F.R. pts. 466 and 476 (1988)
36. Final Rule, Organ Procurement Organizations and Organ Procurement Protocols, 53 Fed. Reg. 6526 (Mar. 1, 1988), C.F.R. pts. 405, 413, 441, 482, 485 and 498 (1988)
37. Final Rule, Fire Safety Standards for Hospitals, Skilled Nursing Facilities, Hospices, Intermediate Care Facilities and Ambulatory Surgical Centers, 53 Fed. Reg. 11,504 (Apr. 7, 1988), 42 C.F.R. pts. 405, 416, 418, 442 and 482 (1988)
38. Final Rule, Revisions in Reporting, Recordkeeping, and Other Requirements, 53 Fed. Reg. 12,010 (Apr. 12, 1988), 42 C.F.R. pts. 405 and 434 (1988)
39. Final Rule, OMB Control Numbers for Collection of Information Requirements Contained in HCFA Regulations, 53 Fed. Reg. 16,267 (May 6, 1988), 42 C.F.R. pt. 400 (1988)
40. Final Rule, Medicare, Medicaid, and Clinical Laboratories Improvement Act (CLIA) Patient Confidentiality Rules, 53 Fed. Reg. 48,645 (Dec. 2, 1988), 42 C.F.R. pts. 74, 405 and 441 (1988)

41. Final Rule, Miscellaneous Medicare and Medicaid Amendments, 54 Fed. Reg. 4023 (Jan. 27, 1989), 42 C.F.R. pts. 409, 410, 416, 421, 424, 441 and 489 (1988)
42. Final Rule, Approved Information Collection Requirements and Federal Medical Assistance Percentage Computation, 54 Fed. Reg. 21,065 (May 16, 1989), 42 C.F.R. pts. 400 and 433 (1988)
43. Final Rule, Revisions of the Laboratory Regulations for the Medicare, Medicaid and Clinical Laboratories Improvement Act of 1967 Programs; Corrections, 55 Fed. Reg. 33,907 (Aug. 20, 1990)

PROPOSED RULES

1. Proposed Rule, Prospective Reimbursement for Rural Health Clinic Services, 47 Fed. Reg. 54,113 (Dec. 1, 1982)
2. Proposed Rule, Medicare, Medicaid, and Maternal and Child Health Services Block Grant Programs; Civil Money Penalties and Assessments for False or Improper Claims, 47 Fed. Reg. 58,309 (Dec. 30, 1982)
3. Proposed Rule, Conditions of Participation for Hospitals, 48 Fed. Reg. 299 (Jan. 4, 1983)
4. Proposed Rule, Withholding the Federal Share of Payments To Recover Medicare or Medicaid Overpayments, 48 Fed. Reg. 6304 (Feb. 10, 1983)
5. Proposed Rule, Schedule of Limits on Home Health Agency Costs per Visit for Cost Reporting Periods Beginning on or after July 1, 1984, 49 Fed. Reg. 20,616 (May 15, 1984)
6. Proposed Rule, Schedule of Limits on Home Health Agency Costs per Visit for Cost Reporting Periods Beginning on or after July 1, 1984, 49 Fed. Reg. 21,375 (May 21, 1984)
7. Proposed Rule, Schedule of Limits on Home Health Agency Costs per Visit for Cost Reporting Periods Beginning on or after July 1, 1984, 49 Fed. Reg. 23,078 (June 4, 1984)
8. Proposed Rule, Utilization and Quality Control Peer Review Organization (PRO); Assumption of Responsibilities and Medicare Review Functions and Coordination of Medicaid With Peer Review Organization, 49 Fed. Reg. 29,026 (July 17, 1984)
9. Proposed Rule, Revisions in Reporting and Recordkeeping Requirements, 51 Fed. Reg. 6429 (Feb. 24, 1986)
10. Proposed Rule, Fraud and Abuse; Revisions to OIG's Sanction Authorities, 51 Fed. Reg. 24,857 (July 9, 1986)
11. Proposed Rule, Benefit Period Determinations, Drug Regimen Reviews and Other Technical Changes, 51 Fed. Reg. 17,997 (May 16, 1986)

12. Proposed Rule, Limits on Payments for Drugs, 51 Fed. Reg. 29,560 (Aug. 19, 1986)
13. Proposed Rule, Limits on Payments for Drugs; Extension of Comment Period, Availability of Data, and Clarification, 51 Fed. Reg. 33,086 (Sept. 18, 1986)
14. Proposed Rule, Fire Safety Standards for Hospitals, Skilled Nursing Facilities, Hospices, Intermediate Care Facilities and Ambulatory Surgical Centers, 52 Fed. Reg. 2430 (Jan. 22, 1987)
15. Proposed Rule, Organ Procurement Organizations and Organ Procurement Protocols, 52 Fed. Reg. 28,666 (July 31, 1987)
16. Proposed Rule, Revaluation of Assets, 52 Fed. Reg. 39,927 (Oct. 26, 1987)
17. Proposed Rule, Survey and Certification of Health Care Facilities, 52 Fed. Reg. 44,300 (Nov. 18, 1987)
18. Proposed Rule, Miscellaneous Medicare and Medicaid Amendments, 52 Fed. Reg. 48,127 (Dec. 18, 1987)
19. Proposed Rule, Changes to Peer Review Organizations Regulations, 53 Fed. Reg. 8654 (Mar. 16, 1988)
20. Proposed Rule, Medicare, Medicaid, and Clinical Laboratories Improvement Act (CLIA) Patient Confidentiality Rules, 53 Fed. Reg. 10,404 (Mar. 31, 1988)
21. Proposed Rule, Revisions to Conditions of Participation for Hospitals and Conditions for Coverage of Services of Independent Laboratories and Conditions for Coverage of Suppliers of End-Stage Renal Disease Services, 53 Fed. Reg. 22,506 (June 16, 1988)
22. Proposed Rule, Revision of the Clinical Laboratory Regulations for the Medicare, Medicaid, and Clinical Laboratories Improvement Act of 1967 Programs, 53 Fed. Reg. 29,590 (Aug. 5, 1988)
23. Proposed Rule, Denial of Payment for Substandard Quality Care and Review of Beneficiary Complaints, 54 Fed. Reg. 1956 (Jan. 18, 1989)
24. Proposed Rule, Medicare/Medicaid Programs; Fire Safety Standards for Hospitals, Long-Term Care Facilities, and Intermediate Care Facilities for the Mentally Retarded, 55 Fed. Reg. 31,196 (Aug. 1, 1990)